

# **Outcomes of Member Input on Proposed Alignment of Medicare and Medicaid Services**

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Summary of Input from Dual Eligible Members\*  
who have a Serious Mental Illness (SMI) and are  
receiving Behavioral Health Services

**April 2012**

**Report Prepared by Empowering Leaders for  
Arizona Department of Health Services (ADHS), Division of Behavioral Health Services**

\*Dual eligible members have both AHCCCS and Medicare Coverage

# **Input on One Health Plan for “Dual Eligible” Members**

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# **Input on One Health Plan for “Dual Eligible” Members**

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## **Purpose of the Report**

The purpose of this report is to provide a summary of the input gathered during focus groups held for members receiving behavioral health services who have a serious mental illness (SMI), who also have both AHCCCS and Medicare coverage. These members, are commonly referred to as "Dual Eligible," and navigate three different systems to receive care. Therefore, the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services, Division on Behavioral Health Services (ADHS/DBHS) are considering a pilot project that would automatically enroll dual eligible members into one Regional Behavioral Health Authority (RBHA) for mental health coverage, AHCCCS coverage and Medicare coverage. Focus groups were adopted as the means to gather the members and their family members or representatives' opinion of this pilot project.

A total of 8 members attended. There were 3 additional members who were not dual eligible and they chose to stay in the meeting as they saw this as an opportunity to learn more about the proposed pilot.

## **Methodology**

The stakeholder engagement process, including the methods of outreach, and locations, was as follows:

- The focus groups and outreach to members were conducted in collaboration with two community partners: Partners in Recovery, located in Mesa, which offers a range of recovery-focused services and Visions of Hope, a Peer Run Organization located in Phoenix.
- Both meetings were conducted by ADHS/DBHS and were held on March 28 and 29<sup>th</sup>, 2012.
- ADHS/DBHS provided a flyer with logistical information and requested the host sites to provide flyers to their dual eligible SMI members and post throughout their sites. Host sites called their members for whom they had a valid phone number on file or mailed them the flyer. The flyers were also available online at the [ADHS/DBHS website](#), under the NEWS area.
- Each flyer included the website address where an online survey could be completed if the member was not able to attend the meeting.
- A toll-free phone number was provided in the flyer in case the member had questions about the meeting: 1-800-867-5808.

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- Questions used to solicit input are included in Attachment A.

### **Executive Summary**

The members recognized a number of benefits of automatically enrolling dual eligible members into one aligned plan provided there was no reduction in services and the opt out option was preserved. The members’ input highlighted that supplemental benefits were very important to maintain in any change.

Concerns raised by implementation of an aligned plan focused on the needs of members being overruled by streamlining; the spread of stigma to the physical health side; continuity of care being disrupted; and any potential loss of benefits. A theme that emerged from both focus groups related to implementation of an aligned plan had to do with the different treatment approaches in comparing member experiences with physical health and behavioral health. The features of behavioral health service delivery that they have found to be supportive are prevention, recovery-oriented and a team approach. One person described her behavioral health team as a doctor, nurse and case manager. Members’ experience with the physical health side is the opposite. For example, preventative medicine is not experienced on the physical health side, yet, as one member said, “all behavioral health is geared toward preventative.” They would like to keep the behavioral health model approach.

Another theme that the focus groups highlighted is the need for:

- Extensive communication of the changes, using multiple methods – not just the internet; and
- Training and education for members about all the links in the service chain. Examples of key people in the system to be trained are case managers and peer support specialists.

The importance of training members on the meaning of the terms used was highlighted by the use of “alignment.” The question regarding member input on having one health plan introduced the term “alignment” as another way to refer to one plan. Alignment had a range of meanings for the participants, including having one doctor; or just one computerized system, with no other changes; to getting medications in one place.

The need for education permeated the input, from knowing when auto-enrollment was coming, details on the opt-out period, to the basics of what is covered and if there are any changes in coverage.

### **Summary of Input from Members/Consumers**

#### **a) Input on a Program that Enrolls Dual Eligible Members into One Plan (AHCCCS and Medicare)**

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Overall the members saw a number of benefits of automatically enrolling dual eligible members into one RBHA for their mental health coverage, AHCCCS coverage and Medicare coverage.

Favorable comments included:

- The possibility of having one plan could eliminate some of the existing confusion; it might be easier to understand and manage. One plan could bring more light on the challenges and the coverage for Behavioral Health services.
- Medication may not cost as much under one plan.
- One participant from the focus groups knew that she had AHCCCS/Medicare under one umbrella for her physical needs. Her comment was that it makes things much easier when she goes to the doctor.
- One focus group was unanimous in their endorsement of one health card. One person said he carries 3-4 cards. Overall, one card was considered helpful.
- It would be a benefit if the member could go to one facility and have both their physical health and behavioral health services.

### **Auto Enrollment, Opt Out Option & Supplemental Benefits**

The key features that the members were invited to provide input on were auto enrollment; opt out option; and supplemental benefits. In general, the members felt an important part of auto enrollment was to be fully informed in advance and that auto enrollment be linked to opt out, so that choice was preserved. Continuation of supplemental benefits was also critical, with benefits such as dental, vision, wellness, transportation and housing mentioned specifically.

The following covers specific input that was received, related to auto enrollment, opt out option & supplemental benefits.

### **Auto Enrollment & Opt Out**

- The importance of advance notification of auto-enrollment was mentioned in order to avoid a member being automatically enrolled without the member

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realizing a change has taken place. The key is to be informed about what is going on.

- The ability to opt out was uniformly supported. The ability to make a personal choice was important. And, along with that, the need to be informed was critical. By “informed” the members meant a) being provided with a good understanding of what is covered by the one plan that the member would be automatically enrolled in; and b) what the other options are if the member chose to opt-out.

### **Supplemental Benefits**

- On supplemental benefits: It’s important that the new plan does not take anything away. Members don’t want to lose any of the benefits they currently have.
- Dental care was mentioned frequently. One member pointed out that it is a real need when on “psych” meds, due to the side effect of dry mouth. They are interconnected.
- Vision was also important; other benefits mentioned were wellness programs, transportation and housing.
- One member said all Medicare Advantage plans should offer the same benefits; some have more services than others.

### **Concerns**

The members raised concerns associated with the implementation of automatically enrolling dual eligible members into one RBHA for their mental health coverage, AHCCCS coverage and Medicare coverage. Those concerns covered if there was any possible loss of benefits; the needs of members being overruled by streamlining; the spread of stigma to the physical health side; continuity of care being disrupted; and losing the positive features of the behavioral health model of prevention, recovery-oriented and a team approach.

The following covers specific input that was received, regarding concerns

- One member feared this could mean she would lose her AHCCCS benefits. The member said “You have to do so much to get AHCCCS, you don’t want to give it up to anything else.” Another member expressed a related concern that some of the services are going to go away.
- Another comment was “People are forgotten in the emphasis on streamlining the computer systems.”

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- Members were also concerned that an increased likelihood of stigma would likely increase and play a part on the physical health side since their behavioral health information would be widely available. For example, one participant expressed the value of the two systems being separate as it allows her to keep the hope that someday she will be free from being certified SMI.
- Continuity of care was mentioned a number of times as very important. For example, the concern is if there are any problems getting medication renewals, it could be very disruptive. One member said he is finally on the right medications and has adjusted to their impact and side effects. An interruption in those medications would have a negative impact. This concern was mentioned in both focus groups.
- Different treatment approaches in physical health and behavioral health were also discussed and there is concern that care coordination would shift to the physical health side (i.e. assigning the responsibility to a PCP). On the physical health side, from the member experience, is that the focus is clinical only. A few comments related to this include:
  - One member has never had a physical health professional understand her symptoms.
  - Another member said stigma creates a relationship with a physical doctor that makes it difficult at times. If the coordination was from the Behavioral Health side, it would be more comfortable.
  - One member shared it would be more important to have his psychiatrist coordinate his care, as he has not been physically sick for two years.
- Participants in one group expressed uniform fears about change.

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### **b) Experience with Current System**

#### **What do you like about your current health plan?**

Overall AHCCCS benefits are very important to the members. As one person said “I want AHCCCS to be around for me, so I can get services when I need them.” Aspects of their current health plan coverage the members mentioned that are positive included the Freedom to Work program, the ability to take classes towards a GED, more individualized approach to ISP’s, and the referrals work smoothly between AHCCCS and Medicare.

The following covers specific input that was received, on their positive experiences.

- Members highlighted the value of Freedom to Work program, health insurance for qualified individuals who are working and who have a disability. A member said, “I have nothing but good things to say about this program.” The member said it allows her to afford to go to the doctor, better financially support herself, and keep her independence.
- Other member was very positive about the option to take classes towards his GED. It helps him grow, and get exposed to different possibilities and people.
- One member observed that she has seen a positive change in the clinics’ approach to Individualized Service Plans (ISP’s). The Provider Network Organizations (PNO’s) are offering more customized ISP’s that are geared to the person’s needs, and are also up to date. Previously, the member’s experience was that she was signed up for more services than she needed.
- Once a referral is initiated, the referrals work fine between AHCCCS and Medicare.

#### **Challenges:**

A key theme in the current challenges was the importance of a having someone help them navigate their questions, the paperwork and accessing their benefits. Participants found their health plans complicated, and so it was helpful to find someone who could help them answer questions, or go through the paperwork with them. Places where members found help included their group home, a case manager, a peer, and/or a family member. Since not all SMI members have computers, it is not always helpful when they are directed to a website. As one consumer said the most helpful approach is “Someone sits down with the individual and says this is Medicare, this is AHCCCS and this is you. And, here is what you are eligible for.”



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For members in both focus groups, questions 3 and 4 were confusing. (See Attachment A for questions.) They did not know if they were in original Medicare (#3). And when asked if they knew that their AHCCCS health plan may also serve as their Medicare health plan (#4), the question was very confusing to them. In one group, they pulled out their health cards in order to have help answering.

The following covers specific input that was received, on the challenges with their current plan.

- Transportation: Some members have to take several buses to get to their appointments. One member heard that the cab fare is going to increase and was concerned that they would not be able to afford it.
- It is very confusing when there are too many options for different services the member doesn't need.
- Need more counselors who have “been there,” as one member expressed it; a counselor “who has slept in the dumpsters.” Some counselors have very little experience, i.e. 6 months.
- There is a waiting list for counselors. What would help during the waiting period is having more peers trained in counseling, having a Wellness Recovery Action Plan (WRAP) and Dialectical Behavior Therapy groups (DBT).
- Need some support with housing. Example given was the member's place was infested with mice.
- Dental plan information is not very clear and dentists are not as knowledgeable as the physical doctors on what is covered and what is not covered by their health plan. For example, a member was told by the dentist that they did not accept a specific health plan. The member learned that they needed to say the name of the organization their health plan contracted with for dental in order for the dentist to realize it was covered.

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## **Attachment A: Focus Group Questions for Members/Consumers**

The following questions were asked for ADHS/DBHS & AHCCCS Forums for Dual Eligible Members, held in March 2012.

### **Introduction**

Sometimes we use the term “dual eligible” to refer to people who are eligible and enrolled in both Medicare and Medicaid, or AHCCCS as it is known in Arizona. AHCCCS and ADHS/DBHS have asked us to obtain input from dual eligible consumers and their family members or representatives about your experience with AHCCCS and Medicare. This session is specifically designed for dual eligible individuals with a Serious Mental Illness (or your family member) who are receiving services from the Maricopa County RBHA.

Your input will be collected and will be part of a final report that will include input from other consumers and family members, as well as healthcare providers, advocacy groups and others. An on-line survey is also available at the AHCCCS website. The final report on this outreach and engagement process will be shared with AHCCCS and ADHS/DBHS so that they can consider your feedback in their efforts to improve healthcare for dual eligibles. Please know that there is no risk in sharing your comments. We will not provide your names to anyone. Your comments will remain anonymous, so feel free to be open with sharing your thoughts and experiences.

### **Experience with Current System**

1. All of you are signed up with a health plan for your AHCCCS benefits for physical health. What do you like about that? What are some of the challenges?
  2. All of you are signed up with a RBHA – Magellan -- for your mental health benefits. What do you like about that? What are some of the challenges?
  3. How many of you are in Original Medicare and are not accessing your Medicare benefits through a health plan at all? What do you like about that? What challenges have you experienced? Who do you call when you are having difficulty getting an appointment or when you are confused about what your benefits are?
  4. Did you know that right now your AHCCCS health plan may also serve as your Medicare health plan? If you did know that, did you sign up with your AHCCCS health plan as your Medicare plan? How satisfied have you been with that choice? If you did know that but did not sign up with your AHCCCS plan for Medicare, why not?
- Questions for ADHS/DBHS & AHCCCS Forums for Dual Eligible Members March 2012
5. Do you know which of your doctors is signed up with your AHCCCS health plan and which of your doctors signed up with your Medicare plan? Is this confusing for you?

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### **What are AHCCCS and ADHS proposing?**

6. AHCCCS and AHDS/DBHS are considering a program that would automatically enroll dual eligible members into one RBHA for your mental health coverage, AHCCCS coverage and your Medicare coverage. Enrolling dual eligible members into one health plan for both AHCCCS and Medicare is also often referred to as alignment, so you might hear us use that term sometimes. What questions does this idea of alignment raise for you? What do you see as the benefits of alignment? What do you see as possible disadvantages or concerns?

7. For example, would it make things easier for you to only have to work with one health plan when you have questions about what benefits are covered for your AHCCCS, RBHA and Medicare services? Would it help you to only have one insurance card? What are the downsides to only having one health plan?

8. What do you think the advantages are to being automatically enrolled in the RBHA for your Medicare? What concerns does this automatic enrollment raise for you?

9. What if you knew you could opt out of this program? That means you still have a choice of Original Medicare or a different Medicare Advantage plan if it turns out that you are not satisfied with the RBHA plan for your Medicare coverage. Does this make a difference to you?

10. Did you know that some Medicare Advantage health plans are able to offer you extra or supplemental benefits? Some of these include vision or dental. In this program that AHCCCS and ADHS/DBHS are proposing, your AHCCCS benefits will stay the same. But there may be some impact on the extra or supplemental benefits that your Medicare health plan is allowed to offer you. Would that be important to you?

Other

11. Is there anything else that you would like to say to the team that will be working on developing this program?

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### Attachment B: Behavioral Health Glossary

The following glossary is a comprehensive list of frequently used acronyms in behavioral health. It is provided by the Division of Behavioral Health Services at:  
<http://azdhs.gov/bhs/updates/BHsglossary.htm>

#### **A**

**ADHS** - Arizona Department of Health Services – The state agency that manages behavioral health care services.

**AHCCCS** - The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program. If someone is Title XIX (19), he or she is enrolled in AHCCCS/Medicaid. Title XIX, AHCCCS and Medicaid refer to the same program in Arizona.

#### **B**

**BHS** - Another abbreviation for the Division of Behavioral Health Services.

#### **C**

**COE** - Court Ordered Evaluation is when a judge orders a person to receive a psychiatric evaluation.

**CPSA** - Community Partnership of Southern Arizona is a Regional Behavioral Health Authority.

#### **D**

**DDD** - Division of Developmental Disabilities, a division of the Department of Economic Security that provides services to those with developmental disabilities.

**DES** - Department of Economic Security, the agency that works with the Arizona Health Care Cost Containment System to determine medical eligibility for Title 19/Medicaid services.

**DBHS** - Division of Behavioral Health Services – The Division within the Arizona Department of Health Services that manages behavioral health services provided by the state.

**DTO** - Danger to Others is a clinical diagnosis that someone may cause harm to others.

**DTS** - Danger to Self is a clinical diagnosis that someone may cause harm to themselves.

#### **F**

**FIC** - Family Involvement Center is a not-for-profit, family-directed organization that assists and supports families/caregivers with children experiencing emotional, behavioral, or mental health disorders.

**FPL** - The Federal Poverty Level is set by the federal government and used as a basis for deciding eligibility for programs across the country. Someone is considered below the federal poverty level if they make less than \$10,830 as an individual or \$22,050 as a family of four.

**FY** - A fiscal year is a 12-month period used by states, companies or other organizations to produce an annual budget, but does not necessarily begin in January and end in December. Arizona's fiscal year begins July 1 and ends June 30 of the following year. For example, FY10

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begins July 1, 2009, and ends June 30, 2010, and FY11 begins July 1, 2010, and ends June 30, 2011.

### **G**

General Mental Health is a classification of diagnoses that is not Seriously Mentally Ill; these diagnoses are not so severe that people cannot function without intense services and medication(s).

### **I**

**ISP**- Individualized Service Plan is a plan that a person receiving behavioral health services develops with his/her case manager to outline his/her treatment goals and methods to achieve those goals.

### **K**

**KidsCare** – KidsCare provides low- or no-cost healthcare to Arizona children. It is part of the federal Children's Health Insurance Program, which is administered by AHCCCS, the same agency that operates Medicaid and Medicare. If someone is Title XXI (21), he or she is enrolled in KidsCare.

### **M**

**MHA** - Mental Health of America, a non-profit organization that advocates for those diagnosed with a mental illness.

**MIHS** - Maricopa Integrated Health Services is the public health service system for residents of Maricopa County.

**MIKID** - Mentally Ill Kids in Distress is a service provider that provides support and assistance to families in Arizona with behaviorally challenged children, youth and young adults.

### **N**

**NAMI** - National Alliance on Mental Illness is a non-profit advocacy group for those receiving behavioral health services and their families.

**NARBHA** - Northern Arizona Regional Behavioral Health Authority.

**NP**- Nurse Practitioner

### **O**

**OBHL** - The Office of Behavioral Health Licensure ensures that facilities providing behavioral health services on behalf of the state meet certain guidelines and requirements.

### **P**

**PCP** - Primary Care Physician is a doctor that provides general medical care.

**PC** - Prescribing Clinician is a member of a clinic team that has the authority to prescribe medications.

**PIP** - Practice Improvement Protocol is a set of guidelines and best practices established by

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ADHS/DBHS for clinicians to follow to ensure proper behavioral health services are provided.

**PM** – The Provider Manual describes direct service delivery requirements to behavioral health service providers across the state of Arizona.

### **R**

**RBHA** - A Regional Behavioral Health Authority provides behavioral health services through a contract with the state in designated Geographic Service Areas (GSAs); there are six RBHAs in Arizona.

**RFP** - Request for Proposal is a call for bids on a contract for goods, services, etc.

**RN** - Registered Nurse

**RSA** - Rehabilitation Services Administration

**RTC**- Residential Treatment Center

### **S**

**SAMHSA** - The Substance Abuse Mental Health Service Administration

**SA** - Substance Abuse is the use of illegal substances like illegal drugs and prescription drugs; it also includes using substances in ways other than intended like gasoline, household chemicals, etc.

**SMI** - Seriously Mentally Ill is a diagnosis that means the illness is disabling and requires intense behavioral health services and medication(s).

**SSA** - Social Security Act is the federal government act that mandates Title 19 and Title 21 benefits.

**SSI** - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income. It also provides cash to meet basic needs for food, clothing, and shelter.

**SSDI** - Social Security Disability Insurance pays benefits to those deemed disabled if they are "insured," meaning that they worked long enough and paid Social Security taxes.

**SSN** - Social Security Number is the number issued to U.S. citizens for identification purposes.

### **T**

**Title XIX/T19** - Title 19 benefits are provided through the Medicaid federal entitlement program; benefits are delivered in Arizona through the Arizona Health Care Cost Containment System.

**Title XXI/T21** - Title 21 benefits are a separate benefits program funded by federal dollars; in Arizona, this program is provided through AHCCS and is known more commonly as KidsCare.

### **U**

**UPC** - Urgent Psychiatric Care is a facility that provides behavioral health care to those in crisis for no more than 23 hours, after which they are referred to another inpatient or outpatient service provider.



## **Arizona Department of Health Services Division of Behavioral Health Services**

### **Summary of Input from Behavioral Health Providers Regarding Coordination of Care**

**March 2012**

#### **Background Information**

On March 7, 2012, the Arizona Department of Health/Division of Behavioral Health solicited input from providers who serve individuals with general mental health (GMH), substance abuse (SA), or children regarding care coordination of services. Care coordination is frequently described as the process by which members are linked to social supports and medical services, breaking down the boundaries between systems of care, assisting members and families, and facilitating communication between all parties involved in the care of the individual.

#### **Participants**

Forty-one (41) providers participated in the forum. The provider forum was held at ADHS's meeting facility (Room 215 A and 215B) from 3:00 – 5:00 pm. Seven (7) questions were posed; the participants were divided into 8 groups, each group assigned to answer one particular question, and then subsequently answering the remaining questions. Groups 1 & 8 were assigned Question 1. Five providers were on conference call for additional input.

#### **Executive Summary**

- Providers were in agreement that coordination of care for children is a much more robust process than that of the adult population.
- Communication between behavioral health providers and primary care physicians is generally fragmented when it comes to care coordination. An integrated grand rounds communication approach would help the process for care coordination.
- Most providers practice the team approach to coordination of care but some were concerned with the inconsistency of the process.
- There is a systems issue and cost associated with care coordination that BH and PCP providers bear when it comes to care coordination. Technology has failed at bridging systems so that an overall picture of a patient's diagnoses is assessed.
- The team approach to deliver coordination of care is practiced by most providers including case managers, peer support, CPS, family members, state agencies, provider agencies, psychiatrists, treatment coordinators, etc.
- Some providers cautioned that too many people (3 vs. 18 people) involved in the care coordination process could be inefficient for the decisions that need to be made.
- Providers expressed that both behavioral health and primary care providers do not have the financing available to accommodate a large decision-pool of people – A combined expense might lead to loss of revenue.
- Most providers were in agreement that some type of incentive process needs to be put in place for the care coordination process.
- Providers expressed that education is an area of improvement so that the workforce is better equipped to work through care coordination and agreed that behavioral health training in universities and schools are lacking thereby creating a system that does not promote culture change and vice versa for the primary care providers.
- Providers in general, agreed that lack of shared electronic records through the entire care coordination process hinders the system of care.



- During the session providers expressed the following concerns:
  - AHCCCS and DBHS policies are limiting.
  - The volume of work for both sides (behavioral and acute care) is overwhelming due to lack of resources.
  - Lack of ongoing relationship with the PCP; that is auto-assigned and generates negative responses from all who are involved in care coordination.
- Many providers were in favor of statewide health information exchange in order to improve care coordination for their members.
- Others expressed education as another area of improvement so that the workforce is better equipped to work through care coordination.
- Some providers believe that
  - all acute health care data would help care coordination
  - although data is important, there is a need to educate professionals in how to translate and use the data being provided
  - having primary care providers in attendance at forums aides in the communication and shared concerns over care coordination
- A direct feed from AHCCCS would aide in the care coordination process.
- Including social supports would improve relationships with non-behavioral health providers to advance care coordination while others expressed the need to build relationships with associations and use technology to provide better care coordination.
- Some providers see the need for better cultural exchange by aligning roles and finances in improving relationships for both provider communities.
- Providers described how well they work with the limited resources (highlighted GMH/SA providers)..
- Providers also highlighted Children's services as doing a good job of implementing system of care on every level.
- Providers would like to continue to pursue person-centered-treatment.

Below are the answers received from the providers. Answers are listed as received from each of the groups' notes with minor editing for clarification and readability; they reflect the voice of the providers participating.

#### **Provider's Current Care Coordination Efforts, Barriers to Care Coordination**

- Several groups believe that when it came to children's care coordination, the process was robust while others believe that both children and adult care coordination was spotty, one-sided, inconsistent, and minimal at best.
- Means currently used to coordinate care by most providers include:
  - FAX/Electronic reporting
  - Working with all stakeholders
  - In the adult system: use of JPO, PCP, CPS, family, church, CPS
  - In the children system: use of CPS, JPO, PCP, DDD, schools, family
  - Psychiatric services
  - Health risk assessments for adults with AXIS III diagnoses
  - Case management services ie. Doctor's appointments, child and family team meetings
  - Care Coordinators attending inpatient staff meetings, discharges, and ongoing planning to deter future hospitalizations

- Most providers use a team approach to coordinate care for members; however some stated that due to volume, the team approach was not possible due to limited resources and competing priorities (e.g. addressing immediate needs vs. clinical acuity)
- Providers listed the following as **barriers** to coordination of care/services with the acute health care system,
  - Inconsistent follow-up and/or non-existent follow-up of members and their progress
  - PCP and BH provider are not distinct in the process
  - Technology systems unable to “talk” to each other – Lack of shared electronic records, claims data, codes not aligned, etc.
  - Case-by-case scenario makes it difficult to gather information
  - Fallacy about PCP’s assigned in AHCCCS is non-existent
  - Unable to find out information regarding chronic diseases and lab diagnostics
  - Occasionally, the PCP is not part of the team
  - No incentives for providers across both sides of the system
  - Culture change – Integration affects culture change when integrating services and should be addressed in schools, universities and current medical staff
  - Philosophical differences in how and what to share
  - Lack of care management
  - Difficulty building relationships for both BH and PCP providers
  - Policy is not aligned
  - Existing staff not well versed/trained in current processes or future changes
  - Resources - Volume of work on both sides of the system is overloaded
  - Member’s do not have a relationship with their PCP – Auto-assigned a PCP
  - Level of funding is inadequate
  - Family members not always included in the hospital discharge process

### Improving Care Coordination

- Suggestions to help better coordinate care include:
  - Integrated electronic medical record including statewide health information exchange
  - Legible writing
  - Use of technology – Cell phones, tables, laptops to convey information
  - Incentivizing physicians – Align incentives; blended payments and fee schedules, integrated CPTs
  - Administrative rules allow for an integrated practice in its licensing and credentialing standards
  - Elimination of stigma
  - IT systems “talk” to each other
  - Basic needs are met – Transportation, housing, food, and employment
  - Need to be open to a matrix model:
    - Virtual integration
    - Co-location
    - Full integration
  - Better education for behavioral and physical providers’ staff
  - Better job of transforming from adolescent services to GMH
  - Direct eligibility feed from AHCCCS
  - Common language between providers/stakeholders

- Peer support
- Consider alternative care solutions in wellness like yoga, use of telemedicine, etc.
- Providers suggested that **relationships with non-behavioral health providers could be improved by:**
  - Including of social supports, PCPs, use of technology and apps to help bridge the gap between child and adults, development of school-based clinics, use of natural community sites (e.g. malls, schools, hospitals, fire departments, colleges, communities of faith, and universities)
  - Identifying cultural leaders who impact social supports as well as the healthcare system, build relationships with associations
  - Becoming educated in order to understand
  - Sensitivity training
  - Broader scope of stakeholder base
  - Developing skill-set definitions (e.g. Medical terminology for behavioral staff and vice-versa for provider staff)
  - Aligning of financial incentives
  - Aligning of EMHR with integrated HIE
  - Allowing for pilot projects regarding integration of care

### **Data & Training**

- Types of data that providers would like to have in the future include:
  - Overall utilization – PCP information, visits, hospitalizations, current medical diagnoses, neurological test results, medication, medical history AXIS I-X information, allergies/adverse reactions, chronic condition, pharmacological data, disease management data, lab results, etc.
  - Comparative data of population as a whole in order to ID outliers
  - EMHR have critical elements and flags
  - A system to identify conflicts between PH and BH so that both parties can focus on the most immediate needs of care
  - Wellness markers
  - Person-Centered-Care – What data does the service recipient need so they can make decisions about informed care
  - Learn from disability communities (like the Deaf and Blind communities) on how to disseminate data
  - Inform family and natural supports regarding what to do with the data
  - Understand what the indicators mean in order to know what the patient needs
- Types of training on data utilization for making decisions regarding coordination of care include:
  - Joint training regarding physical and behavioral health information like understanding discharge summary, notes, treatment planning, etc.
  - How to access information from a shared medical portal
  - Integration of roles
  - Integrated forums/meetings
  - Education of current and future staff about PH/BH processes – Joint training opportunities regarding integrated care
  - Education in schools and universities about integrated care

### **Working Well in Current System (Maricopa County)**

In the children system:

- Current service array
- The 12 Principles
- Family movement (examples mentioned were MIKID and FIC )

In the adult system:

- The 9 Principles
- Peer and family training

Providers also mentioned the following:

- 1<sup>st</sup> responder/early identification
- Effective assessment and triage, no wrong door
- MMWIA, DSP's richness of children's system in terms of staffing
- Specialty services have been developed – 0-5, SO, SA
- Recovery focus
- MMWIA
- Transition of services (no information was provided if this referred to both, or only the children or adult system)
- Development of HNCM in SOCPR
- GMH/SA-Dedicated recovery coach
- Partnership between behavioral health providers-sharing of resources
- Peer-run partnerships
- Flex funds
- Direct support on children's side
- Peer support on adult side
- Emphasis on person-centered treatment – We need to keep pursuing, further to reach
- Crisis system works
- Provider system works well
- Innovation – We have stability
  - GMH/SA-Wide array of services
  - Children
    - CFT Design change
    - Change in assessment tool requirement
    - Intensive case management
    - GMH/SA providers overall are incredibly good at doing well with limited resources. Willingness to share information with population served and as a whole system.
- GMH/SA providers do a really good job at being solution-focused, work well to address and resolve recurring problems.
- On the children's side, providers urged to retain support services (CMS level, psychosocial services); you won't have a system of care if you don't have case management services; may need those services intermittently.
- Go to a medical model and retain those types of services for adult and children. Flex fund is valuable as well as peer support and transition services.
- Treat young adults as their own population. When the 12 principles were created, the 9 principles on the adult side needed to be added.
- Support of cultural competency should not change.
- Recommend expanding codes to include more wellness codes.

**Questions for Non-SMI Provider Forum, March 7, 2012**

These questions apply to providers who serve individuals with general mental health (GMH) issues, substance abuse (SA) issues, or children.

Care coordination is frequently described as the process by which members are linked to social supports and medical services, breaking down boundaries between systems of care, assisting members and families, and facilitating communication between all parties involved in the care of an individual.

- 1) How do you coordinate care for your members in your practice (i.e. PCP visits, chronic disease management, hospital discharges, etc)?
- 2) Do you use a team approach to coordinate care for your members? If so, whom do you include on the team?
- 3) What barriers do you encounter that affect your ability to coordinate care/services with the physical health system?
- 4) What can help you better coordinate care for your members?
- 5) How can you improve your relationships with non-behavioral health providers to better coordinate care? What new relationships would be helpful to you?
- 6) There may be acute health care data made available to you in the future. What data would best help you coordinate care? What type of training do you think you will need to properly utilize this data in making decisions for care coordination?
- 7) Describe what is currently working well in the existing BH delivery system for the GMH/SA population and the children's system of care that you would like to preserve in the next Maricopa County RBHA contract.

For more information and to provide additional feedback about integrating behavioral and physical health care in Maricopa County, visit <http://www.azdhs.gov/diro/integrated/index.htm> and use the "Contact Us" form located in the homepage.

# **Integrated Healthcare System for Persons with Serious Mental Illnesses**

## **Summary of Input from Peers and Family Members**

### **Background Information**

In August 2011, the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) convened a Peer and Family Engagement Work Group to design and implement a process for obtaining input from persons with Serious Mental Illnesses (SMI) and their family members regarding the integration of physical healthcare and behavioral healthcare services (*see <http://www.azdhs.gov/diro/integrated/index.htm> for more details and the latest information about this planned effort*). Work Group members included representatives of peer-run and family-run organizations, AHCCCS, ADHS/DBHS, and St. Luke's Health Initiatives (SLHI).

The Peer and Family Engagement Work Group used Community Based Participatory research, an evidenced based approach used in public health to engage communities that share an issue or concern; and then adopted the use of focus groups as the means to gather the collective opinion of persons with SMI and their families. As a result, the Peer and Family Engagement Work Group asked each peer-run and each family-run organization in Maricopa County to host a focus group and each did so. Six focus groups were conducted at the following organizations: Family Involvement Center (9/22/11), CHEEERS (9/23/11), REN (9/26/11), MIKID (9/28/11), Visions of Hope (9/29/11), STAR West (10/13/11); a seventh was held for the four Maricopa County NAMI-affiliates at the Disability Empowerment Center (10/17/11). Additionally, SLHI conducted nine individual interviews with additional respondents in order to reach some who were not affiliated with these organizations. Questions/topics were developed by the Peer and Family Engagement Work Group and finalized by DBHS. The same questions were used for the focus groups and interviews, although the interviews were tailored to each individual's circumstances. Focus groups were facilitated and documented by individuals with prior training and experience facilitating meetings with peers and families. SLHI helped facilitate the input process and summarized the findings. This document was prepared for publishing by ADHS/DBHS and reviewed by the Peer and Family Engagement Work Group.

### **Participants**

Over 100 people attended some or all of a focus group. Participants were primarily persons receiving services in the public behavioral health system or family members of those receiving services. There were some service providers in the focus group held for the NAMI affiliates—input collected was analyzed recognizing this exception.

### **Findings and Observations**

This report summarizes comments shared in the focus groups and interviews. Where similar comments were made in multiple settings, this is noted; however, the process was not designed to lead to consensus recommendations. Statements in this document reflect the opinion of participants and are not the author's words.

There were some pervasive themes that threaded through the focus groups and interviews. **Peers and family members want a system in which:**

- The administration and providers really LISTEN to them.
- They have VOICE in planning, implementing, and evaluating their own healthcare.
- They are treated with RESPECT and not stigmatized for having a mental illness in either the behavioral health or the physical health aspects of the system.
- Each person is treated as unique and healthcare is INDIVIDUALIZED accordingly.
- Providers are HIGHLY SKILLED in serving persons with Serious Mental Illnesses.
- Services are coordinated, consistent, and of high QUALITY.
- The focus is on improving health OUTCOMES and ensuring health EQUITY.

### ***Impressions about an Integrated Healthcare System***

With few exceptions, participants liked the concept of an integrated healthcare system as long as there would continue to be a choice of quality providers and the ability to change providers. Participants noted that **an integrated healthcare system offered potential for the following:**

- Coordination of medications. This was a common concern among participants because of the potential for medication interactions and adverse side effects. Many felt it would be beneficial if the prescribing providers were well aware of all the medications that the individual was taking and of all the individual's health conditions and health issues.
- More holistic approach to healthcare. Many spoke about the importance of being treated as a whole person and of various providers looking at the interaction of the mental, emotional, and physical aspects of health.
- Better communication among all team members. While some noted that an integrated system is no guarantee of better communication among all team members, it does offer the potential via shared health records and perhaps via co-location of some services.
- Greater accountability for healthcare delivery and health outcomes. Some noted that the leadership of the health plan sets the tone for the whole organization. If the contract requires accountability for both service delivery and for health outcomes, this could lead to improvement at all levels of the organization.

Participants also expressed the following **concerns for consideration in the design of integrated healthcare:**

- Confidentiality. While there are advantages to having both behavioral health and physical health providers in the same health plan, some were concerned that their medical records might be shared beyond a need to know. Some stated that they did not want all their providers to know everything about them for varying reasons.
- Loss of current providers. Perhaps the most commonly mentioned concern was the potential for having to change primary care doctor and/or specialists. Several participants commented that it had not been easy for them to find a primary care physician or specialists with whom they could work well and feel comfortable. If they could keep the same doctors, they would support integration of systems, but they would not support it if it meant losing their chosen providers.
- Choice of providers. Concern was expressed about having fewer choices of doctors and reduced quality of providers among those contracting with the integrated health plan.
- Access to specialists. There were many questions about how referrals to and delivery of services from specialists would work.
- Service array. Some participants expressed concern about losing some of the services they currently receive and really need.
- Formularies. Some participants expressed concern about losing coverage for specific medications that they are taking at this time.
- Wait time. Although primarily related to co-located services, several participants expressed concern about integration resulting in a longer wait time to see the doctor, either the primary care doctor or the psychiatrist.
- Decision making/authorizations. There were questions about who had the final say in an integrated healthcare system and whether the primary care doctor would serve as a gatekeeper for behavioral health services, as well as other medical specialty services, or vice versa.
- Changes to the current behavioral health service delivery model. There were questions about whether the current service delivery model would change, e.g., clinics, peer-run organizations.
- Communication and coordination. There were concerns about mechanisms that would be put into place to ensure communication and coordination of service delivery among providers in the integrated healthcare system. It was noted that being on one health plan or even in one location would not be sufficient to ensure communication and coordination.
- Stigma. Some were concerned that the creation of a "Specialty RBHA" would serve to further stigmatize persons with SMI. One person noted that this should not be a carve-out, but rather a fully integrated health plan.

A small number of participants expressed support for greater integration of service planning and delivery, but not necessarily under a single health plan.

### ***Integration with Medicare***

There were mixed opinions on the value of integrating a person's Medicare plan with the integrated behavioral/physical health plan. On the positive side, it was noted that full integration would facilitate billing and be less confusing. Some commented that they already had their Medicare and Medicaid services through the same health plan and that this worked well for them. Concerns focused primarily on fear of losing services and increased out-of-pocket costs.

### ***Co-location of Services***

There were mixed opinions about the co-location of primary care and behavioral health services. Some seemed to like the idea very much for the following reasons:

- Ease of access. This would reduce the need for transportation and make it convenient to see the primary care doctor. This might be particularly beneficial to seniors or those with mobility challenges. It could result in getting in to see the primary care doctor sooner.
- Better coordination, possibly leading to improved healthcare. If the doctors were in the same place, it might be easier for them to review an individual's healthcare plan, status, medications, etc. and might be conducive to more integrated healthcare.
- Improved likelihood of getting care. Some noted that it is sometimes difficult to encourage their family member to go to the doctor. Having a primary care doctor at the clinic might increase the probability that the person would see the doctor.

Some were opposed to co-location; others who were not categorically opposed still had concerns. The concerns included the following:

- Space. It was noted that it would be hard to incorporate primary care services into existing clinic locations.
- Scale. Some participants were concerned about the clinic taking on a warehouse appearance and feeling. One person asked if this would be like going to the Veterans' Hospital. Some commented that this could be addressed by providing services on different floors of an office building and having different entrances for different purposes.
- Contagion. Some participants were concerned about people with contagious medical conditions being in the behavioral health clinic with those whose immunity might be compromised.
- Length of wait time. There was some concern that people would have to wait a long time to see the primary care doctor if he/she were located in the clinic.
- Lack of choice. Some expressed concern that the individual would not have a choice and would need to be seen by the primary care doctor who was working that day. Concern was expressed about the quality of care if the primary care doctors were full time at the clinic and saw no one other than individuals in the behavioral health system.
- Stigma. Once again the issue of stigma was mentioned and concern expressed about being relegated to one location where only persons with SMI would be served.

### ***Choice***

When asked if would be important to have a choice of integrated health plans, most indicated that they would prefer a choice, although a few said that it did not matter much to them. Advantages of having a choice of integrated health plans were greater competition for members and more accountability to members, hopefully leading to better healthcare.

Participants felt that there absolutely had to be a choice of doctors, both psychiatrists and primary care doctors, and that everyone needed to have the information required to make an informed choice of providers, whether or not they had a choice of plans. At least one respondent indicated that an important choice for him/her would be whether to see the primary care doctor at the clinic or in the doctor's private office.



Another issue related to choice that came up in several focus groups and interviews was the choice of whether to opt-in or opt-out of the integrated health plan. Some indicated that they would be willing to consider getting their behavioral/physical healthcare from the same health plan, but wanted the option of deciding to continue with the arrangement they currently have if they were not satisfied with the choice of providers in the integrated health plan.

**Concerns about not having a choice included the following:**

- Formularies. Some choose their health plan based largely on whether the medications they take on an ongoing basis are included in the formulary and not all health plans are the same in this regard.
- Consistency and quality. Participants were very concerned about the consistency and quality of care, particularly if they have chronic medical conditions. Keeping a doctor or other provider that is a good fit for the individual is a major concern. Several participants indicated that they would choose the health plan that includes their primary care doctor and/or specialists.
- Coercion. A few participants expressed concern about being forced to see a primary care doctor if they did not want to do so or being dropped from behavioral health services for non-compliance with the primary care doctor's orders.
- Resources. A concern was raised about the adequacy of resources to make a choice of plans a reality.

***Enrollment of AHCCCS-Eligible Family Members in the Same Integrated Health Plan***

Opinions on whether to include AHCCCS-eligible family members were mixed. Some thought it would be easier for families if they could all be enrolled in the same health plan as long as there was a choice of health plans. Some plans, it was noted, might be more child or family-friendly than others. **Other than family convenience, advantages might include:**

- Better recordkeeping and better familiarity with the whole family, which would facilitate taking the health of the whole family into consideration in the treatment of any one member.
- Early detection of genetic predispositions and initiation of prevention services.

Several participants had no dependents or other family members who were AHCCCS-eligible or enrolled. While several of them thought the idea was promising, they had no direct experiences and, therefore, no strong opinions on the subject.

A few were opposed to the concept and their reasons varied. Others were not necessarily opposed to coverage for families, but simply did not want their children coming to the behavioral health clinic to receive primary care services, if services were to be co-located.

**Other concerns voiced include the following:**

- Appropriateness of providers. If children were to be seen, the health plan would need an array of pediatricians and children's specialists.
- Service array. Some felt that it would not be feasible to provide the array of services needed for people throughout the lifespan.
- Waiting time. Some were concerned that seeing family members would lengthen the wait time to see the primary care doctor.
- Costs. Some inquired if covering families would increase or decrease costs.
- Care coordination. There were concerns about how care to the family would be coordinated.
- Choice. There were concerns that the whole family might be required to see the same primary care doctor.

### ***Care Coordination***

The questions posed focused on coordination of care rather than case management. However, in some cases the two concepts were blurred in the responses; this must be taken into consideration when reading the comments below.

Several participants said there should be a neutral party charged with care coordination; that is, someone who does not “work for” either the psychiatrist or the primary care doctor. Several said that care coordination should be a responsibility of the case manager or case worker (distinctions were not made between these two titles). One participant said the care coordinator should not have more influence than the clinicians on the team. Others who might serve as the care coordinator mentioned by one or more participants included the following: a peer, the primary care physician, the psychiatrist, a social worker, a nurse, the site manager, and a medicine man. Some commented that care coordination should not be the responsibility of the primary care doctor due to concerns about behavioral health needs being overshadowed by other health needs. They felt that behavioral health should “drive” the process. Several participants expressed that there should be no care coordinator and that this should be done by the person him/herself or the family, if possible. A few participants commented that the care coordinator should be whoever relates best to the individual and that this would vary from person to person. Another commented that care coordination should be shared among the team members.

It was noted that whoever is charged with care coordination functions needs to have knowledge of Serious Mental Illnesses, experience working with persons with Serious Mental Illnesses, a thorough understanding of behavioral health related medications and their side effects, and familiarity with the physical healthcare system as well as the behavioral healthcare system. The care coordinator needs to listen to the person for whom they are coordinating care and know the person well enough to support their active participation in their own healthcare. The care coordinator should have at least a bachelor’s degree, receive ongoing training, and have regular performance reviews. Functions of the care coordinator should include ensuring that all providers involved with the person provide timely information in a format that is understandable to the person and all other team members and supporting the person in navigating all aspects of the healthcare system.

Several commented on the need for a reasonable caseload for case managers and/or care coordinators. The importance of “customer service” was highlighted by many.

Other concerns about care coordination included: how to ensure participation of some persons with Serious Mental Illnesses who may be at times be unable to make their needs known verbally, how to avoid requiring the individual to tell the same story repeatedly, how family voice can be included, how to ensure that doctors share information, and how to ensure communication among team members in general. These are issues that participants would like to see addressed in the care coordination process.

### ***Service Planning***

When asked about their Individual Service Plan (ISP) and desirability of a broader “recovery and wellness” plan, participants had many comments. Most participants who commented on this subject stated that behavioral health and physical health issues should both be addressed in the plan, whatever it is called.

#### **Participants would like the plan to be:**

- Written with their input.
- Correctly reflect their current situation and goals (goals should be real).
- Implemented in collaboration with their case manager and all team members.
- Updated regularly to reflect their changing situation and goals.

It was noted that the plan could have particular value at times of transition, e.g., from school to work, from one type of living situation to another, from the children’s healthcare system to the adult healthcare system. The importance of

focusing the plan on the person's strengths was underscored by some as was the need for individualization and creativity. Participants would like to be provided a copy of the plan.

### ***The Team***

Most who commented on the composition of the team in an integrated system stated that it should include the current team members plus the primary care doctor, specifically the individual him/herself, case manager, psychiatrist, nurse, counselors, rehab specialist, and recreation specialists. There was much support for the inclusion of a peer support specialist and a family support specialist. As one participant put it, "The team should include all who care about and are involved in supporting the person." Some family members felt it was important for them to be on their family member's team, too. At least one person commented that there should be a pharmacist on the team and another noted the important role of the team in medication monitoring. It was noted that the team should take an active role in the implementation of the plan.

### ***Role of the Peer Support Specialist and Family Support Specialist in the Team***

The importance of peer and family support specialists was underscored in the focus groups and interviews. It was noted that peers can help instill hope in the person whom they are supporting. One of the peer support specialists who attended a focus group stated that she received hope from the peer who supported her and that she held that hope until she could then share it with another. Others echoed this in their own words, noting benefits ranging from reducing isolation to helping avoid hospitalization.

From the participants' perspective, the **keys to success are**: having a peer support specialist from the beginning; good matches; quality peer support; low turnover; having consistency in support; having the peer support specialist available as-needed; and having the peer support specialist checking in on regular basis.

When asked about the **roles of peer support specialists**, the following were mentioned: mentor, advocate, role model, "living proof," go-to person, educator, coach, and system navigator. The peer support specialists:

- Listen and share their own stories.
- Support the empowerment of the individual so that he/she can become a better self-advocate.
- Help the individual to communicate.
- Help the individual to prioritize goals.
- Provide information about community resources that may not be known to other team members, the pluses and minuses of the resources, and how to access them.
- Could provide broader peer support to the individual, if they have other physical health issues themselves.
- Could provide professional development to newer clinicians who may have limited experience working with persons with Serious Mental Illnesses.

Several stated that peer support should be written into all plans.

### **Peer support specialists working in an integrated healthcare system will need:**

- Initial and ongoing training and education. Particularly, to support the individual in all aspects of the plan (or ISP), they will need training related to the physical healthcare system.
- Effective supervision and performance reviews.

An environment where confidentiality is respected and boundaries upheld.

While no one rejected the idea of having peer support specialists in an integrated system, there were questions about how this would work and how the peer support specialist would work with the case manager, care coordinator, or both if they were not the same person. It was noted that primary care doctors and other providers in the physical healthcare system would likely need information and training about peer support—how it works and its value.

There was also interest in having family support specialists available. **Family support specialists:**

- Should be family members and should be part of the team.
- Can be instrumental in helping families get through tough times.
- Help families deal with the stigma that is attached to mental illness.
- Offer confidentially for the family to discuss things they don't feel comfortable talking to others about.

The availability of peer and family support specialists should be publicized so that these services are better understood and used often in the integrated healthcare system.

### ***Wellness, Prevention, and Chronic Disease Management Services***

Among those who commented on the subject, there was widespread support for including services to promote wellness, prevention, and chronic disease management in an integrated healthcare system. **The types of wellness, prevention, and chronic disease management programs and services that some would like to see in an integrated healthcare system include the following:**

- Diabetes counseling
- Cooking classes and other nutrition programs
- Weight management programs
- Physical activity (including workout rooms, equipment, and gym memberships)
- Skin care (medication related conditions), smoking cessation programs
- Pain management
- Stress management
- Life skills classes
- Massage
- Acupuncture
- Tai Chi and yoga
- Reminder calls
- Home health checks

The importance of programs and services focused on co-occurring conditions was also noted (including Alcoholics Anonymous and Narcotics Anonymous), as was the importance to health of outings, recreation, and socialization.

Other services suggested include counseling, dental, flu shots, housing, mobile health screening (such as mammograms and HIV screening), peer support, prenatal care, respite, support groups, transportation, vision, and well-woman exams. The importance of educating those receiving services about behavioral health, diagnoses, medications, etc. was highlighted, as was the importance of having time for discussion of these and other issues with one's primary care doctor and psychiatrist.

The importance of taking a holistic approach to health was highlighted, as was the importance of individualization. It was noted that activities need to be adult-oriented and designed to reduce rather than heighten stigma. Food served in clinics and other programs should be healthy and appealing, in order to reinforce the health messages. In the integrated system, there should be opportunities for lifelong learning about health and chronic disease management. There should be an emphasis on self-management of chronic diseases and peer support to assist with this (assuming peer support specialists have the requisite training on the subject). Furthermore, there should be recognition that behavioral health conditions and medications taken to address them may contribute to problems such as overweight, poor oral health, lack of physical activity, and such. Special attention and supports should be available to help counteract these factors. Several commented that peer and family support is an important tool in the promotion of wellness. **The only concern noted was the potential cost of offering an array of wellness, prevention, and chronic disease management programs.**

## *Technology*

When asked about the use of technology for purposes ranging from electronic health records to personal health management, **some benefits identified included:**

- Medication monitoring and management (biggest one).
- Improved access to an individual's health information by various team members, including the individual him/herself, the primary care doctor, the psychiatrist, and other specialists (individuals also expressed desire to be able to enter notes in their own health records.)
- Convenience. One family member who was interviewed spoke of the benefit of her son being able to locate and make an appointment on-line for his blood draw with a lab near his home, which was far more convenient for him than the prior process had been.
- Ease and speed of communications. While acknowledging that access does not ensure communication, it was noted that this would at least facilitate communication. One participant noted that it would be beneficial if it were possible to communicate via email with the behavioral health clinics.

### **Concerns included:**

- Accuracy of electronic information, confidentiality (including who has access to what data), data security, back-up systems, and data recovery plans.
- Lack of internet access. Some/perhaps many individuals with SMI do not have access to computers in order to access on-line information, educational materials, or health management resources.
- Need for training both on how to access on-line resources and how to understand information in the health records.
- Technology doesn't always work as planned.
- Technology should not replace human interaction.

## *Other Considerations Related to an Integrated Healthcare System*

Other issues that surfaced during the focus groups and in the interviews included the following:

- Serving people who are diverse in language and culture. The importance of being able to serve persons whose primary or only language is other than English was noted by several participants, as was the importance of understanding the impact of culture on health and healthcare.
- Providing clear and simple information about eligibility, costs, etc. There were questions about whether there would be any changes in eligibility in an integrated healthcare system, as well as questions about out-of-pocket costs.
- Engaging a competent and sufficient workforce. Concern was expressed about having a sufficient pool of high quality providers, particularly primary care doctors, who understand behavioral health. The issue of turnover in psychiatrists was mentioned by participants and there was concern that there might be similar turnover in primary care physicians, which is not typically experienced in the physical healthcare system. Participants also spoke about the creation of new employment opportunities in an integrated system. They underscored the importance of requiring or at least making available training for those who would be working within an integrated system. The issue of compensation was mentioned, noting the importance of paying well enough that high quality providers are attracted to and stay in the system.
- Licensing. Questions were raised in one focus group about the impact of behavioral health licensing standards on an integrated healthcare system.
- Coordinating with other non-health related programs. There were questions from a few participants about the Freedom to Work Program and how this might be impacted by integrating the healthcare system.
- Surviving budget cuts. Concern was expressed about the impact of any future budget cuts, with at least one mention of fear that it would be easier to cut an integrated system than each of two separate systems.
- Ongoing involvement of persons with Serious Mental Illnesses and their families in planning, implementing, and evaluating the healthcare system. There was support from many participants for continuing to seek out and

engage those who are impacted by services in the process of designing, developing, implementing, and evaluating the new system.

- Serving persons who are not designated as having Serious Mental Illnesses and a non-Title XIX population. Concern was expressed about persons who are in the “General Mental Health” population, as it was noted that there are individuals in this population whose needs are similar to persons designated as having with Serious Mental Illnesses. Concern was also raised about those how are not Title XIX eligible. There were also questions about how changes in the adult system will impact the children’s behavioral health system and the transition between the two.

### **Additional Focus Groups**

On November 18, 2011, an additional focus group was held primarily for persons of African American descent. There were 22 participants, the vast majority unfamiliar with the public Behavioral Health system or mental illness in general (3 -5 participants may have been members/family members based on their knowledge and answers, there was no way to tell with certainty without explicitly asking the person to self disclose). While responses collected did not provide new information, the desire to have an advocate role in the system was expressed several times (i.e., each person in the system should be assigned an advocate).

On December 13, 2011, an additional focus group was held primarily for persons of Hispanic/Latino descent. There were at least 4 confirmed member/family member participants out of 8 total participants. Participants in this group expressed support for the health home concept and having their healthcare services through one health plan. They liked the idea that family/dependents get their healthcare through the same health plan as the person with SMI. They suggested that social workers get the role of care coordinators. They desire to have peer support specialists play a role in the new plan or system and they support the use of technology (i.e., would like to access their own health information online).

## **Attachment 1**

### **Focus Group Questions**

Q1: First, thank you to those who put themselves out there in doing the video. What caught your attention in the video? What did you like or not like about the idea of getting all your health care through the same health plan?

Q2: If a single health plan is created to oversee all your health and behavioral health services, you may no longer have a choice of health plans, even though you would still have a choice of doctors. Do you have any concerns about that? If so, what are they?

Q3: Many individuals with Serious Mental Illnesses have dependents or family members who are also on AHCCCS. Would it be helpful if dependents or family members could be enrolled in the same AHCCCS health plan as you (...or their family member who has a Serious Mental Illness)?

Q4: A health home is an approach or way to give integrated care that means that, besides having the same health plan for your psychiatrist and your primary care doctor, all the team members in your recovery plan have to work together. Who should be responsible for coordinating all the team members? Where should the coordination of services take place?

Q5: If you have Medicare coverage, would you prefer to get all your services, including those covered by Medicare, from the same health plan?

Q6: Can you describe how an ISP helps you to meet your recovery and wellness program?

Q7: In the Raise Your Voice focus groups, it was noted that peer support services are important to you because peers are uniquely qualified to listen, help, and offer hope to one another. What role should the peer support specialist or family support specialist have in your recovery plan?

Q8: Many individuals with Serious Mental Illnesses die 25 years younger than the rest of the population. An integrated health care delivery approach may help people with Serious Mental Illnesses live longer. Keeping that in mind, what types of wellness, prevention, and other services would you like to see provided to promote recovery, help you stay healthy, and help you manage your illness or health problems?

Q9 Today, technology is being used to support wellness, treatment, and care coordination in health care—from electronic health records, to web-based patient education, to tracking your health on-line. Does using technology in these ways appeal to you? What concerns do you have?

Q 10: Is there anything else you would like to add?

# **Integrated Healthcare System for Persons with Serious Mental Illnesses**

## **Summary of Input from Providers**

### **Background Information**

In December 2011, the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) solicited input from service providers that serve persons with Serious Mental Illness (SMI) in the public behavioral health and acute care systems, regarding the integration of physical healthcare and behavioral healthcare services (see <http://www.azdhs.gov/diro/integrated/index.htm> for more details and the latest information about this planned effort). St. Luke's Health Initiatives (SLHI) facilitated the input process. *Note: throughout this report, the term (health plan) "member" is used to refer to the person with a Serious Mental Illness and the term "provider" is used to refer to those who deliver healthcare services to the member.*

ADHS and AHCCCS engaged in a variety of outreach efforts to encourage providers to attend focus groups. In addition to posting information on the ADHS/DBHS website, a number of organizations were contacted including the Arizona Council of Human Service Providers, the Arizona Medical Association (ArMA), the Arizona Osteopathic Medical Association (AOMA), the Arizona Academy of Family Physicians (AAFP), and AHCCCS health plans. All providers who serve persons Serious Mental Illness under a contract with Magellan Health Services of Arizona were invited as well.

All focus groups were held at SLHI in Central Phoenix. For those who were unable to attend in person, SLHI offered the option for participation via teleconference or phone interview. Three focus groups for behavioral health providers were conducted on 12/9/11 and one on 12/14/11. An additional focus group with acute care providers was held on 12/12/11.

### **Participants**

Approximately 50 providers participated in the focus groups. Participants in the first four focus groups included members of the Council of Human Service Providers and other provider agencies including some that currently contract with Magellan Health Services of Arizona. Participants in the fifth focus group included primary care providers, specialists (including psychiatrists), and an emergency room physician.

Additional input was obtained via phone from a physician who was unable to attend a focus group and opportunities to be interviewed were extended to two others who have not responded to-date. An interview was conducted with a behavioral health provider who has knowledge of issues related to transition age young adults (18-21 years of age).

### **Executive Summary**

- Providers uniformly support better coordination among behavioral health and other healthcare providers in a person-centered and integrated healthcare system that promotes better health outcomes for persons with Serious Mental Illnesses.
- In developing an integrated healthcare system, the overarching principle should be the needs and preferences of the member. These, rather than rules, should drive system design.
- Providers see the value of co-location of acute care and behavioral health care but have differences of opinion on where and how this might be achieved. Concerns include impact on member choice and recruitment/retention of primary care physicians to work in the behavioral health setting.
- Providers see the value of an expanded healthcare team which includes the member, the primary care physician, and behavioral health providers, plus specialists as needed. All members should have access to a peer support specialist, a care coordinator/navigator, a wellness coach, and others, as needed and preferred. There is a need for a team leader to coordinate the work of the team. All roles should be defined functionally, rather than simply having a list of titles required for each team. There should be sufficient flexibility to allow for changes in team composition as the member's needs and preferences change over time. The team should be responsible for continuity of healthcare over time, even when there is turnover in team members.
- Communication among the team and the member would be greatly facilitated by having an electronic medical/health record that is timely, accurate, comprehensive, easily accessed, understandable, and



appropriately protected. Other forms of communication should include some face-to-face, augmented by various forms of electronic communication.

- All members and providers should receive training on integrated healthcare and related topics, so that they can participate fully and attain the greatest benefits. Ideally, information on integrated healthcare would be embedded in professional education and reinforced through ongoing training. Concerns were raised about the amount and type of training required. An alternative approach was to require certain competencies of those working in the integrated healthcare system, rather than prescribing training and education requirements.
- Establish outcomes that address improvement in both physical and behavioral health and that focus on benefits to the member. Outcomes (and payment rates) should not create disincentives to serving those with the greatest need nor to those seeking services that are truly needed. Incentives rather than penalties should be explored, but performance should be considered when making contracting decisions.
- Electronic medical and health records are essential to the success of an integrated healthcare system. Concerns focus on development of system specifications, implementation of the specifications, changes to specifications once implementation has begun, and costs.
- Payment should reflect all the requirements and be sufficient to cover the costs of planning, training, communication, coordination, implementation, evaluation, and other functions required to provide integrated and effective healthcare to adults with Serious Mental Illnesses.
- All systems that impact service delivery need to be in alignment with an integrated health care model. These include contracting, licensing, training, leadership, auditing, contract monitoring, payment, incentives, evaluation, recordkeeping, etc.

#### **Concerns (Behavioral Health Provider Focus Groups)**

Some of the major concerns expressed (when specifically asked this final question) were:

- Loss of choice for service users, impact on members
- Potential for loss of peer support
- Minimizing attention to behavioral health in an integrated healthcare system
- Losing the good things that have been built or not building on lessons learned from the carve-out model
- Integration of two disparate cultures
- Ensuring there is a focus on wellness and recovery
- Ensuring that providers are engaged in building the system
- Concern that the RFP will be too specific and not allow for the flexibility needed to develop and improve a newly integrated system; too much dictated by rules, requirements, and processes
- Need to remove silos (including funding, licensing, leadership, etc.) in order to create a truly integrated system
- Need education for all involved
- Costs and availability of adequate funding, potential for increased administrative costs and loss of service dollars
- Need for final licensing rules prior to implementation and clarity about how integrated healthcare will be licensed
- The transition process
- Resorting to brief solution-focused treatment, when more extensive or specialized treatment is indicated

#### **Concerns (Acute Care Provider Focus Group)**

Some of the major concerns expressed (when specifically asked this final question) were:

- How we will know if the pilot is working and producing the desired results
- Developing a workable model
- Concern that there are not enough acute care providers
- Ensuring that members are seen where they are, not only in the office
- Piloting the concept in Maricopa County may be too much
- Cuts in services
- Navigating the system
- Sub-specialty populations, e.g., adults with developmental disabilities

## **Detailed Findings and Observations**

Questions asked in the focus groups and interviews are listed in Attachment 1. Responses from behavioral health provider focus groups/interview and the acute care provider focus group/interview are reported separately below. Please note that statements in this document reflect the opinion of participants and are not the author's words.

### ***Co-location of Services***

#### **Behavioral Health Provider Focus Groups:**

Most participants favored bringing primary care providers into the behavioral health setting. Co-location may facilitate improved communication, coordination, and collaboration, but it is not sufficient to produce these desired benefits. It might be better to talk about *integrated services* rather than *co-located services*, as the latter still conveys a separation. Even if services are co-located, there would still be need for care coordination and system navigation assistance for the member. In order to truly integrate health care and hopefully improve health outcomes for persons with Serious Mental Illness, well functioning teams will be needed as well as shared records and competent providers.

Benefits of co-location include:

- greater and more timely access to primary care and specialty services;
- increased likelihood of getting and accepting primary care services;
- increased referral for a range of needed healthcare services;
- more timely attention to emergent health problems;
- better attendance (fewer no-shows for primary care services);
- better compliance with healthcare recommendations;
- increased efficiency benefitting both the member and the healthcare provider;
- reduced need for access to transportation;
- improved cross-consultation to address an evolving medical/psychiatric problem;
- improved provider communication, better care coordination, improved collaboration to foster wellness and address health issues ("integrated thinking").

Concerns about co-location include:

- Reduced member choice in selecting a primary care provider or keeping a valued primary care provider;
- the philosophy that promotes active member involvement in his/her own healthcare might be diminished;
- the model of co-located services might not be feasible in rural areas.

Participants also asked if members would be able to opt-out of co-located services and which services would be made requirements for co-location.

#### **Acute Care Provider Focus Group:**

Some acute care providers commented, as did behavioral health providers, that co-location is likely to increase utilization of needed healthcare services and that this would benefit the member. However, regardless of whether services are co-located or not, there is a need for a shared record, better communication among providers, and continuity of care, leading hopefully to better health outcomes.

While some liked the idea of locating primary care doctors in behavioral health settings, there were concerns about recruiting and turnover of physicians. Some felt that locating behavioral health providers in a primary care setting might be a better option, but there were concerns about space, as many primary care doctors have small practices. Large medical practices are already including or considering offering behavioral health services in their practice. Another option mentioned was to regionalize so there are integrated teams but team members are not necessarily located in the same building. However, the full range of specialists needed realistically could not be co-located with either the primary care doctor or the behavioral health specialists.

Telemedicine was mentioned as an alternative or adjunct to co-location. One provider in the group (a psychiatrist) reported that she was already using this option satisfactorily and that most payors accept this model. Others disagreed that this was a good option for persons with Serious Mental Illnesses or other chronic problems.

Some commented that co-location, or others models of integration, will not address the issue of persons with Serious Mental Illnesses dying at an earlier age than the general population if there are insufficient resources for needed services. As was the case in the focus groups for behavioral health providers, having access to and using common information and functioning as a team were seen as keys to successful integration and improved healthcare for persons with Serious Mental Illnesses.

### ***Member Involvement***

#### **Behavioral Health Provider Focus Groups:**

There was strong support for member involvement in the development, implementation, and evaluation of the individual's healthcare plan. (The term "healthcare plan" is used here because focus group participants often commented on the importance of the plan addressing wellness and prevention, not only treatment of healthcare issues.) Members might need support from a trusted person of their choosing in this process and that unrealistic expectations should not be placed on the member. Members should have choice in all aspects of the healthcare plan and should receive complete and understandable information on the options available to them. Benefits of member involvement include increased buy-in and compliance with the plan.

#### **Acute Care Provider Focus Group:**

Participants in the acute care provider focus group also commented that the member should be involved in the development of the healthcare plan, but some noted that the involvement would depend on the member's preferences and competency at the time and that this might change over time. One participant commented that compliance with a healthcare plan is proportional to the member's involvement.

### ***The Team—Composition and Functioning***

#### **Behavioral Health Provider Focus Groups:**

When designing the integrated care system, the function of the team needs to be clearly defined. With respect to the composition of the team, there was agreement that those who are currently on the team should continue to serve on an integrated healthcare team. There was general agreement that a peer support specialist should be offered for each team, but some noted that the peer should be someone who is a peer in a larger sense, if possible (e.g., a person with a Serious Mental Illness and diabetes). Several participants thought that having a Pharm. D. on the team would be a major asset. Several also mentioned the inclusion of a health/wellness coach. Others mentioned inclusion of a nutritionist and employment coach, as needed. There should be consideration of natural supports when identifying critical team members, e.g., friends and family. Specialists and their role within the team need further consideration, but there should be provision for their inclusion when needed.

There were cautions about defining team composition too precisely, as each member is different and his or her situation changes over time. Composition of the team should take into account the needs and preferences of the member and some existing models, e.g., CODAC's program, could be considered.

There was general agreement that there is a need for a single point of contact for the team (a "go-to person"). The team leader would be responsible for convening the team and facilitating meetings. When specifically asked who should function as team leader, participants offered several options, including the care coordinator, the case manager, the member, the person with fiduciary responsibility, a peer support specialist (with back-up), a nurse (e.g., psychiatric LPN), a physician, or a social worker. Few felt that the position should be defined by the type of degree held. Some felt that the member should choose the team leader. Key qualifications for someone functioning as the team leader would include general knowledge of the full range of the healthcare system (behavioral health and acute care) and ability to facilitate communication among team members. It was noted that no one person can be an expert in all aspects of

integrated healthcare, but that there should be specialized training for a person filling this role so they are prepared to carry out the functions assigned and know how to obtain additional information when it is needed. One participant noted that who employs the team leader could make a difference and, therefore, this needs further consideration.

Every member should have access to a care coordinator/navigator. It was not clear if this should be the case manager or someone else, but several expressed concern that case managers not be overloaded (as they are now). Some important roles to be considered are: assisting with eligibility, ensuring appointments are made and kept, coordinating the array of services provided, following up on services and team commitments, making sure supports are in place, advocating for the member, and generally keeping everything on track. Another important function is supporting the engagement of the member and making sure the member is informed. The qualifications of the person(s) who carry out these functions will depend on the specific functions assigned to team members.

It was noted that payment must be available to support the functions of the team and all members of the team, including the team leader, care coordinator, peer support specialist, etc.

#### Acute Care Provider Focus Group:

Acute care providers also mentioned that the team composition would depend on the needs of the member. They noted the importance of having a social worker and/or case manager on the team. Specialists also need to be on the team, but they may not always be “at the table.” It was felt that having a Pharm. D. would be a major asset to the team, given concern for appropriate medication management. Care coordinators and/or system navigators were also recommended.

The team would follow the member throughout time and be familiar with the member’s longitudinal history (e.g., who saw the member for what, when, and what the results were). It was noted that the team needs to follow the person wherever they are, even if the person is living on the street. Medication monitoring was seen as a critical function, which could be aided by an electronic healthcare record.

There is a need for a team leader and the person performing this function could change over time. Sometimes it could be someone in behavioral health and at other times, an acute care provider depending on the issues at any point in time. The team leader needs to be accountable. The team leader could be a physician, a medical case manager, or someone else in a coordinating role, not the leader in a clinical sense. The team leader would need good facilitation skills and should know how to function in a team environment. One participant indicated a strong preference for this to be the primary care physician. As was the case in the focus groups for behavioral health providers, the importance of sufficient payment for this function was noted.

It was recommended that care coordination be available to each member. If the function were primarily coordinating services, it could be carried out by an experienced social worker or nurse case manager. A physician would not need to serve in this capacity.

### ***Peer Support Specialist***

#### Behavioral Health Provider Focus Groups:

Most thought that a peer support specialist should be offered to all members to perform a variety of different tasks for which he/she is qualified. In an integrated healthcare system, it would be desirable to think about peer support in a broader context, e.g., to have a peer support specialist who has personal experience both with Serious Mental Illness and the same chronic condition as the member, e.g., diabetes, cardiovascular disease.

In order to expand the role of the peer support specialist beyond the behavioral health system to the integrated healthcare system, it will be necessary to clearly define functions and communicate them to the peer support specialist, healthcare providers and members. Member choice should be paramount in determining the functions of the peer support specialist.

It would be desirable for the peer support specialist to be a neutral party, ideally a contractor rather than an employee of the agency/clinic where the member is receiving services.

#### Acute Care Provider Focus Group:

Some participants were not familiar with the concept and function of a peer support specialist. It was noted that there are a variety of successful models for providing peer support. There was general support for teams including a peer support specialist if the member chooses to have one. It was noted that having a peer support specialist as an “opt out” would result in higher utilization than having this as an “opt in.”

### ***Team Communication***

#### Behavioral Health Provider Focus Groups:

Communication would likely be enhanced by co-location, but there is no guarantee. Access to electronic medical/health records would contribute significantly to timely and regular communication. Remote access to the record would be essential, as would having a single repository for information. *See comments below under the heading Electronic Records for additional information.* Other forms of communication include phone, fax, email, text, teleconferences, videoconferences, etc. Some were supportive of the use of telemedicine. It was noted in all the focus groups that face-to-face communication would also be needed, although some commented that everyone who needs to be involved may not be able to be seated around the same table at the same time and that communication could take place virtually. Key team members would need to meet on a regular basis and the member should be part of the team meeting. Provision needs to be made for regular communication with specialists, too. At a minimum, the member should see at least one team member at each visit.

There is a need for improved communication among persons in the behavioral health system, in the acute care system, and between the two systems. To achieve effective communication, a common language will be needed, as will a better understanding of the disparate cultures that exist in various aspects of each system. There was a caution about stereotyping—those in the behavioral health system stereotyping the acute care system and vice versa. Cross-training would be needed, as noted below under the heading Training and Education, as would joint staffings. Communication would be aided by having clear, shared outcomes. Also, not all those involved with the member will have access to all the available information regarding the member. There needs to be clear guidelines and authorizations in place to govern this process.

The benefits of timely and regular communication include continuity of care, especially when there is turnover in team members; better treatment; and ultimately better outcomes.

The adult system needs to be developed to reflect that members are adults and have a significant role in their own healthcare.

With respect to using technology to communicate, the member might need training and/or support from a peer to utilize and feel comfortable with using technology.

The payment rate should be established to support required communication among team members. There are very different expectations in the behavioral health system and the acute care system related to number of visits per hour/day and there are very different requirements related to what needs to be done.

#### Acute Care Provider Focus Group:

As in the behavioral health provider focus groups, participants spoke about the critical role of the electronic record and the importance of having access to a health information exchange. They suggested that quick access to complete and timely information was critically important. They also indicated that various forms of communication would be needed, particularly through electronic means. The importance of personal communication and core team meetings was noted, although this might be aided by video chat technology, as it is not always realistic to have everyone in the same place. If teams were regionalized, it might be more feasible to have face-to-face team meetings.

Communication can be further facilitated by the use of technology, e.g., automatically turning acronyms into language all users understand, flagging critical information such as drug interactions. A major concern is medication management and technology can help with this.

Members need to be included in team communications. One participant recommended that members carry with them some form of identification that includes the name of someone on their team so that the team can be alerted in an emergency situation.

Those in the focus group for acute care providers spoke at some length about the need for better communication between providers delivering outpatient services to a member with providers delivering inpatient services. Better communication would solve problems such as a primary care physician not knowing that a member has been admitted to a hospital. Furthermore, medications may be changed while the member is hospitalized and, upon discharge, the member may not know which medication regime to follow, may not have an adequate supply to cover the time until he/she can see the primary care doctor (or specialist), or may not be able to afford the prescribed medications due to the formulary in use. Inpatient providers need to be involved with the team during the period of hospitalization.

### ***Training and Education***

#### **Behavioral Health Provider Focus Groups:**

The importance of persons within the acute care and behavioral health systems understanding each other was noted in every focus group. Some felt that there is a need for a major shift in thinking toward an integrated healthcare system—not simply two systems understanding each other. Ideally, training and education would take place with a range of provider types coming together. Some training and education would need to be made available electronically and would need to be accessible at times convenient for the providers.

Ideally, training and education should start in school, e.g., medical school, nursing school, and be carried into residencies and subsequent education and supervision for healthcare professionals. In the short term, there should be modules on key topics developed and presented to all those who will be involved in the integrated healthcare system. Messages delivered through training and education activities should be consistent. The training and education should address philosophy, culture, language, format for staffing, expectations, requirements, etc. Training and education should highlight the role of the member in his/her own healthcare. Some noted that persons in the acute care system need considerable training and education to treat persons with Serious Mental Illness and both need cross-training. Management staff in an integrated healthcare system should also be provided with proper training and education. Training should be provided by experts, e.g., certified health education specialists, primary care physicians, mental health clinicians. Shadowing might be a good approach to help facilitate understanding.

There were cautions about loading additional requirements on top of current requirements (CMEs, CEUs). Time required for participation in training and education should not be prohibitive. New requirements should not be layered on to existing requirements, but rather all requirements should be revisited in light of the integrated system. Persons in different roles may need different training and education. The payment rate should support participation in required training and education.

There were questions about licensing requirements and how these might need to change to facilitate the implementation of an integrated healthcare system in all respects, not only training and education. An alternative view was to require certain competencies, rather than specific training, and demonstrate that competencies are met.

Participants talked about the importance of providing training and education for members, too, so that they understand the integrated healthcare system. In addition, members could benefit from health education, particularly related to any chronic health conditions they might have. Members could also benefit from training on resources and how to access them, ranging from health to employment.

#### Acute Care Provider Focus Group:

The need for training and education related to integrated healthcare in medical school and residency was voiced by participants. It was noted that there is competition for students' time and space in the curriculum, but there have been some efforts to integrate training and facilitate cross-discipline interactions among those in healthcare training programs (including physicians, nurses, social workers, pharmacists, and nutritionists).

In the short term, there will be a need for a required module on integrated healthcare. This could be made available on-line with a post-test. Training and education should accommodate a variety of learning styles. The training should be provided not only to primary care and behavioral health providers but also to emergency room physicians, specialists, and hospitalists.

Training is needed on electronic medical/health records as well as the concept of integrated health care, the health home, etc. Providers need to get comfortable with using technology, and some still are not.

As in the other focus groups, there was concern that required training and education not be an add-on to other requirements, but rather that all requirements be revisited. Training and education requirements should not create a disincentive to participation in the integrated healthcare system. The payment rate should support participation in required training and education.

Some thought that there would be a need for a face-to-face, retreat-type meeting of providers within both systems to define expectations and begin the process of creating a common culture. Web-based training could be an adjunct but would not take the place of this type of team-building experience. It was noted that this would be a good investment and help to create a more functional team.

#### ***Outcomes—Defining, Data, and Incentives***

#### Behavioral Health Provider Focus Groups:

Participants discussed the appropriateness of the outcomes listed in the question (i.e., reducing hospital admissions, reducing emergency room use, reducing care costs, improving the care experience, improving health outcomes). Some felt that it would be important to look at the reasons for hospitalizations, emergency room use, and high costs, so that the measures do not create a disincentive to appropriate use of services. Some did not think these were the right measures, other than health outcomes.

Many commented on the need for additional measures, particularly measures to address the effectiveness of behavioral health services and wellness/reduction of risk for medical conditions. Examples mentioned included: improved quality of life; decreased use of emergency shelters; increased ability to engage in self-advocacy; increased ability to live independently; stable housing; better relationships; greater civic engagement; employment/education; goal attainment; decreased incarcerations due to symptomatic behavior; fewer pre-petition court screenings; acuity of symptoms; ambulance use; reduced duration of hospitalization; integrating pharmacy formularies for greater cost containment and documentation of medications prescribed; and improved health indicators such as weight, blood pressure, and blood sugar. It was noted that the outcomes should focus on the entire healthcare system, including hospitals. Measures selected and targets established should be appropriate for the population of adults with Serious Mental Illness. One participant recommended adopting SAMHSA's national outcome measures.

There was some discussion about additional data that should be considered when evaluating the overall performance of the integrated healthcare system (i.e. persons going outside the health home for services).

There was a question about whether the data would be population based or member specific. If it is the latter, baseline data would be needed for each member.

Outcome data should be generated via an automated system, wherever possible. Some thought AHCCCS should be able to produce much of the outcome data. There were concerns about the burdens of data collection, analysis, and reporting. The costs of providing outcome data should be reflected in the payment rate.

In analyzing the data and drawing conclusions, it would be important to consider external factors that might affect the results obtained, e.g., policy, statutes, resource limitations, length of time to be seen in a non-emergency setting as it relates to increased emergency room use.

There was more support for incentives than for penalties. Some commented that poor performance should be addressed via the contracting process—don't contract with entities that are not performing. It was noted that attention is needed to the rate paid. The rate itself may provide an incentive to produce good outcomes. Caution should be exercised in establishing incentives for reducing care when the care is needed to produce longer term positive outcomes. Furthermore, the system should not create disincentives to serving those with the greatest need, offering choices, or holistic healthcare. There may need to be some form of risk adjustment to address acuity.

One participant suggested providing incentives for offering integrated healthcare and team work. It was noted that there may need to be some form of start-up funding at the RBHA level. Community providers cannot afford to create the new infrastructure and would need assistance.

It was suggested that members be provided with “report cards” on the providers to inform decision making.

Billing codes should also be examined. Some that are defined as administrative are essential to delivery of integrated healthcare services.

An evolutionary approach was recommended, recognizing that the integrated healthcare system will take time to develop and may not initially produce maximum benefits.

#### Acute Care Provider Focus Group:

All five measures listed in the question are important. Member and family satisfaction/perception of improved well-being should be added as a measure and there should be some health risk reduction measures, e.g., smoking cessation. Other suggestions included wait time for care, how quickly prescriptions are being filled, and measures related to poly-pharmacy. In the longer term, there should be a focus on increasing the lifespan in this population. Agreement on the outcome measures and their definitions would be needed up-front. Improving the care experience and improving health outcomes particularly need better definition. A comment was made that “simpler is better” and that the teams should have a role in deciding how to measure the outcomes.

An objective third party would be needed to collect, analyze, and report the data. Data should be shared widely. As with the provider focus group, the issue of member specific or population based data was discussed. An electronic data collection system will be essential for collecting and analyzing data.

With respect to incentives and/or penalties related to achievement of outcomes, participants preferred incentives to penalties. Some felt that incentives were more effective in changing behavior than were penalties. It would be important for the system to incentivize real desired results. One participant commented that an option would be to determine the baseline cost and then share savings resulting from integrated healthcare, taking future costs into consideration. Concern was expressed that providers do not have control over some of the proposed outcome measures.

### ***Electronic Records***

#### Behavioral Health Provider Focus Groups:

Electronic medical/health records (EMR/EHR) are seen as a major facilitator of improved communication and coordinated treatment (especially medication management), leading to better health outcomes. A certified EMR should



be required; however, the health home record is only one part, albeit an important part, of the member's overall health record.

Information needs to be up-to-date, easily retrievable, understandable (not too little and not too much), and written in respectful language. The system should be able to produce data quickly. It should facilitate recordkeeping, communication among providers, practice management, and good clinical care. It needs to work for all involved—members, funders, the health plan, and providers. It would be best if data could be entered and accessed from remote locations.

Members should have access to their record and be able to write to it, particularly to enter disputes and correct errors. There should be a consumer portal and training for them on how to use their record.

Access to an electronic Health Information Exchange (HIE) is also essential, so that there is a central repository for information from all involved providers.

Cautions were raised about requiring a particular format for EMRs given the diversity of providers who would need to be part of the integrated health plan. They should all be able and required to contribute information to the EHR. Concerns were raised about system costs and delays in implementation. There were also concerns about State-level or RBHA-level system requirements that come out after a system is in place. Modifications after implementation can be costly. Deadlines are a problem, as providers are often at the mercy of the developers. Attention is needed to the issues of EMR/EHR requirements, costs, deadlines, etc. Both AHCCCS and ADHS/DBHS need to be involved. It was noted that there would need to be dedicated funding for development of an electronic record system, as payments for service are inadequate to cover development costs. There were suggestions about who should pay for which aspects of the system; some noted that the funder should pay for the EHR and HIE, while the RBHA should pay for the EMR, especially if they mandate it. Federal incentives should be explored. There were questions about requirements for and the cost of upgrades and modifications.

Questions that would need to be resolved include data ownership and access. Some may have concerns about what they are entering, so authorizations for use need to be clearly specified. All users should have access to emergency plans, medications, the insurance plans, and demographics.

Providers would be incentivized to keep electronic information up-to-date by simply having a system that works for them and that allows for better coordination of care. It would be even more of an incentive if the system were able to produce outcome data and if the system replaced paperwork rather than duplicating it, e.g., acceptance of electronic signatures, expedited submission of prescriptions to pharmacies. There could be a contract requirement to have an EMR. Requirements for data timeliness and accuracy could be a part of contract compliance. Auditing and other reviews could be tied to the EMR. There could be a financial incentive for use of EMRs. There was a caution not to penalize small organizations and to implement requirements in a stepwise fashion.

#### Acute Care Provider Focus Group:

Some providers might not be willing or able to comply with a requirement for an EMR, at least in the short term. However, electronic records are essential for coordinated care and data sharing. Several benefits of having an EMR were mentioned, e.g., better access to useful reports, improved care and medication management, and ultimately decreased mortality.

Information in the electronic record should be relevant, coherent, sufficiently detailed to provide a complete and accurate picture of the situation, and not too stereotyped (e.g., not simply a series of check boxes). It should provide a picture of the member's history and current condition. With respect to use of flags for critical events, the standards should not be set so high as to result in providers ignoring the flags. Keeping the record simple is desirable. It should allow a provider to see quickly the medications the member has been prescribed, the other providers who are seeing them, and the hospitalizations they have had. The data needs to be "real time," comprehensive, user-friendly, and

supportive of effective care. To meet the requirement of a comprehensive record, an HIE will be needed and all providers would need to contribute data. This has already been done for some other AHCCCS populations.

The member should be able to contribute to the electronic record (e.g., in the “my chart” section).

Choosing the right system will be critical, as this is a huge expense. Flexibility will be needed in the development phase, as it will be difficult to anticipate all the issues in advance. Security issues will need attention and a balance between security and ease of use will be needed. One participant noted that it is difficult to redact an electronic record. It was noted that the perfect system is “not out there” and cost is a major concern. Maintaining the EMR could be a condition of contracting or employment.

### ***Implications for Transition Age Young Adults***

Young adults with Serious Mental Illnesses face some distinctive challenges. Those noted included the following: being placed in a setting with older adults, some of whom may have more serious and longstanding conditions; receiving SSI benefits on their own for the first time and having few skills to handle their own finances; lack of incentive to work and/or inability to find appropriate work; lack of age-appropriate social interactions, and boredom. A participant expressed that healthcare integration could have a positive impact on this age group (although this is not the answer to all the problems noted), if primary care and behavioral health providers would get to know each other and function as a true team. It was noted that it would be critical for young adults to be active participants in their own teams. They need to have teams who believe in them, focus on what is right with them, and embrace the recovery model.

As with other age groups, it was recommended that the team include not only physicians, but also the case manager, counselor, dental providers, eye care providers, prevention specialists, and others who have a role in the young adult’s recovery and wellness. It was noted that a peer support specialist should be included, as recovery is rooted in prior strengths and alliances. The peer support specialist could be an age peer or a mentor who understands and will stick with the young adult. There should be a team leader who makes sure everyone has the needed information to support the young adult. If this is the case manager, they need to have a reasonable size caseload (no more than 30). The team leader could also function as the care coordinator, if caseload sizes were reasonable. The young adult should be empowered to take charge of his/her own treatment, in order to promote adherence to the healthcare plan and reduce the probability of “learned helplessness.”

Cross training of providers serving young adults will be needed and they should be familiar with the distinctive needs and preferences of this population. Respect among the disciplines will be critical. Electronic records and joint case staffings would help promote shared understanding of the young adult and of the role of each provider in supporting the member’s recovery and wellness. All providers will need training in use of electronic records.

With respect to outcome measures and measuring systems, it was recommended that a simple participant assessment system be used, wherein young adults would rate themselves and their interactions with providers. The Client-Directed Outcome-Informed Therapy system was mentioned as an example. There should be incentives to providers for good performance and penalties for underperforming.

As noted above, an electronic record is needed for all ages, but could be particularly useful for young adults who are more accustomed to and comfortable with technology. The challenges of implementation noted were the same as in the focus groups. Data from electronic record systems could be used to track and improve performance at the individual and organizational level. It was noted that “every clinic needs a way to hold people accountable.”

## **Attachment 1**

### **Focus Group Questions**

AHCCCS and the Division of Behavioral Health Services (DBHS) are seeking your input on the planned integration of behavioral health and physical health services in one health plan for Medicaid eligible persons with Serious Mental Illnesses. This would begin in October 2013 and would only be in Maricopa County initially. The input from today's focus group will be used along with that obtained from peer and family interviews and other focus groups that we have been conducting to determine what the issues are and how to best move toward integration of healthcare services and the implementation of "health home services."

Q1: Should primary care services be provided in the same physical location as behavioral health services? (For example, that might mean that a person would see their family physician at the same place that they see their psychiatrist.) Why or why not?

Q2: In an integrated healthcare system, the team would include, at a minimum, the SMI member, behavioral health and physical health professionals. Who else should be on the person's health home team? Should a peer support specialist or similar paraprofessional be offered to the member as an option on every team?

Q3: Describe how a health home team should function. Should there be a designated team leader? Who should that be? How should services or team functions be coordinated?

Q4: How much input or involvement should the member have in developing his or her treatment plan?

Q5: Should a single person be designated to coordinate services? Who should that person be?

Q6: What would help to promote timely and effective communication among team members? What would effective communication among team members look like?

Q7: Describe the training or education that is necessary for providers to effectively deliver integrated health care services. Who should provide the training?

Q8: The success of integrated health care services depends on collecting and reporting outcome data in a number of areas. What is the most efficient way to collect data and report progress in:

- Reducing hospital admissions?
- Reducing emergency room use?
- Reducing care costs?
- Improving the care experience?
- Improving health outcomes?

Are there other outcomes that should be measured and reported? What are they?

Q9: How should financial incentives and/or penalties be used to motivate providers to achieve all of the outcomes just described in Q11? How should the incentives be structured?

Q10: What do you see as the pros and cons of an Electronic Medical Record (EMR)? What potential challenges do you anticipate?

Q11: What would motivate you to consistently use an electronic medical record so it is always current and complete?

Q12: From your perspective as a provider of health care services, what is the one thing you are most concerned about with implementing an integrated health care service delivery model?

***Raise Your Voice!***



**Arizona Department of Health Services  
Division of Behavioral Health  
System Transformation Committee**

**Raise Your Voice Focus Groups Report**

**July, 2011**



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## Introduction

The Arizona Department of Health Services/Division of Behavioral Health (ADHS/DBHS) in collaboration with peer and family members is pleased to publish the findings from the Raise Your Voice (RYV) focus groups.

This report and all of the hard work that went into it represents the commitment, dedication and participation of many individuals at all levels of the behavioral health system. Most importantly, it offers the true voice of peers and family members from the very beginning, starting when this was merely an idea on paper, to the drafting and release of this report. Peer and family members helped design the process; facilitate the focus group sessions, collect and analyze data and write this report. Thanks to these contributions, ADHS/DBHS has a greater understanding of what recovery means and how important it is to peers and family members.

This report is structured for those who are interested in the essence of the findings as well as others who prefer to examine the data in more detail. The first pages describe the process and the essence of the findings. More detail is contained in the attachments to the report including the data and analysis for each question asked in the focus groups. The categories described on the charts are specifically defined for each question using the actual words and phrases spoken and written down in the focus groups.

The findings were organized as follows:

- I. Section I (page 5), the Process, Structure and Operational Steps that occurred to implement this initiative.
- II. Section II (page 8), contains the Findings divided into themes or categories that were developed when analyzing the written responses from each and every focus group.

Note that certain language appears in bold/italics. These passages are the exact words and phrases spoken during the focus groups or actual quotes by focus group participants written down during the sessions.

When preparing this report, ADHS/DBHS was careful to avoid summarizing, interpreting or attaching specific meaning to the responses. ADHS/DBHS strived to report the words, phrases, language and expression directly conveyed by focus group participants; therefore, the report does not include conclusions or a statement of what this means at the end of the report.

Nonetheless, peers and family members taught ADHS/DBHS the following valuable lessons:

1. Recovery is a nonlinear process that varies from individual to individual; it entails achieving concrete outcomes or goals which are easier to attain when choice, support and respect are given to peers.
2. Peer and family members were thankful for the opportunity to share their views and opinions of the publicly funded behavioral health system in a safe and structured forum and there is consensus among them that these forums should become a regular way to include peer and family member input into the behavioral health system.
3. Community Based Participatory Research is not only an effective method to involve peer and family members in the planning, organizing, leading and monitoring of the publicly funded behavioral health system; it also contributes to the recovery of peers and is an effective way to decrease stigma.
4. Efforts to strengthen the peer and family voice at all levels of the behavioral health system, both in terms of design and decision-making, is not a luxury— it is a necessity. It makes our system stronger, more resilient and is essential as we look to the future in addressing challenges and changes to the health care system.

## **I. Process, Structure and Operational Steps**

In November and December 2010, twenty-six RYV focus groups were conducted throughout Arizona to gather the collective opinion of members with Serious Mental Illness (SMI) (peers) and family members of the SMI in order to learn what is important to them in meeting their recovery goals. A total of 370 peers and family members attended the focus groups.

### **A. The System Transformation Committee**

For the past year, in response to the budget crisis in Arizona, ADHS/DBHS implemented significant modifications to the behavioral health benefit package for SMI members that did not qualify for Medicaid. These changes, as well as the ongoing fiscal crisis, led to Plaintiffs and Defendants to agree to a Joint Stipulation to Stay Litigation in the *Arnold vs. Sarn* class-action lawsuit through June 30, 2012. The purpose of the Stay Order was to temporarily halt further litigation and enforcement of current court orders while also using this time to negotiate revised court orders.

To address these unique circumstances and plan for future system changes and development of revised court orders, ADHS/DBHS invited peers, family members and stakeholders from other established organizations to design a process in which peers and family members could actively participate in the planning, organizing, leading and monitoring of the publicly funded behavioral health system. This group of individuals became the System Transformation Committee (STC).

### **B. Community Based Participatory Research**

Applying an evidenced-based research method called Community Based Participatory Research (CBPR), the STC developed a process using focus groups to gather the collective opinion of peers and family members. According to the Agency for Healthcare Research and Quality (AHRQ), the CBPR approach emphasizes co-learning, sharing of decision making power, and sharing ownership of the end product. AHRQ defines CBPR as:

*“a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.”*

### **C. Focus Groups to “Raise Your Voice”**

The STC chose focus groups over other survey methods because having a set of predetermined open-ended questions designed by peers and family members allowed participants to express their opinions in their own words. These focus groups promoted



an interactive discussion that often generated new ideas and solutions. The focus groups were conducted in a safe and structured environment where members could freely express their opinions and be assured that their voice was heard. The STC decided to identify this project as “Raise Your Voice.” To further enhance the meaning of this project, the STC adopted the Raise Your Voice logo, which quickly became the symbol of this effort.



#### **D. Focus Group Protocol**

Prior to conducting focus groups, the STC designed a written protocol of seven questions that guided the process for all twenty six focus groups. The protocol allowed every focus group regardless of location or member participation to be conducted in the same manner and within the established two hour timeline. The protocol included an introduction statement, purpose, ground rules and the questions that were developed based on three distinct categories:

- a. Recovery: includes all the aspects of the individual’s ability to live, work and integrate into the community at large, while achieving his or her recovery goals.
- b. Individual: includes the acknowledgment of each SMI member’s unique needs and goals.
- c. System: includes the service delivery system structure to address individual needs and goals.

From these three categories, the STC generated thirty questions, which were eventually collapsed into seven, (refer to **Attachment A** to view the focus group protocol and questions).

#### **E. Focus Group Training and Facilitation**

To provide adequate coverage to help facilitate and manage the focus groups, forty-five volunteer peers and family members participated in training to serve as a facilitator, assistant or scribe. Facilitators were trained to follow the protocol ground rules, keep the discussions focused on the seven questions and finish each session within the two hour time frame. Facilitators received explicit direction to provide clarification and additional information requested by participants without influencing their responses. Facilitators were also trained to remind participants that every opinion was valid and to treat each other with respect when there was disagreement of opinions. The scribe was trained to record the information generated during the focus group discussion and the assistant was trained to set up the room, pass out materials and collect the written answers to the seven questions.

#### **F. Focus Group Locations**

The STC, in collaboration with system partners, selected the focus group locations. Factors in the selection process included access to public transportation, geographic

diversity and the availability of private meeting space in order to have a safe and judgment free environment (refer to **Attachment B** to view the focus groups' schedule). Focus group times varied from morning, afternoon and evening hours to encourage greater participation.

### **G. Outreach**

To publicize the focus groups, the STC in collaboration with system partners, created flyers and posters, which were distributed and posted in strategic locations such as clinics, provider sites and peer run organizations throughout the State. Additionally, ADHS/DBHS created a webpage with the sole purpose of providing the community with regular updates regarding the focus group; this webpage is available at: <http://www.azdhs.gov/bhs/transform.htm>. Once the focus groups were underway, "word of mouth" was used to inform others and encourage participation.

### **H. Focus Group Participation**

In the focus groups in which ten or more persons attended, the participants broke into small groups and were given the list of seven questions. Every small group nominated a participant to write down the group's answers to each of the seven questions on a large pad of paper. When the small groups were finished answering the questions, each one selected a spokesperson to explain the answers to the entire group. This led to a robust interactive discussion among all participants, which was recorded by the volunteer scribe.

### **I. Data Entry and Analysis**

Upon completing the focus groups, each data set collected during the focus groups was labeled and numbered according to a pre-established nomenclature that included, the focus group site, group number and page number, this information was later recorded in an electronic spread sheet for tracking purposes during the data entry phase.

Once all the data sets were labeled, the data were transferred to an electronic data collection form by peer and family members who were trained to follow a data entry protocol and to transfer the information verbatim. The data were later categorized and trended with SPSS Text Analysis software.

While the data were categorized and trended, the STC established a data sub-committee that was responsible for providing direction to ADHS/DBHS during the data analysis process and to report to the STC the decisions and the reasoning for data grouping and trending.

## II. Focus Group Findings

The STC analyzed the information from the focus groups according to the same three categories that were used as the foundation to develop the predetermined questions: Recovery, Individual and System. The narrative below is a summary of consistent themes that were evident in all focus groups for all questions. The language in bold type reflects the actual words from focus group participants taken directly from the written notes. For a more in-depth review of the data and findings, please refer to **Attachment C**.

### A. Recovery

In order to design a behavioral health system focused on recovery, it is important to understand what recovery means to peers and family members.

When asked, peer and family members defined recovery as a personal journey that consists of **fulfilling an array of personal goals that lead to a better quality of life, through this journey or process, an individual gains self-sufficiency, productivity, and independence.**

Peer and family members described recovery as a multifaceted process, because it entails **fulfilling goals** in several aspects of a person's life, such as improving **physical and mental health, gaining or restoring relationships**, furthering education or **vocational skills, improving living arrangements and gaining employment**. Therefore, each person experiences recovery differently, or as one member noted **it is self-defined**. For example, while Jack<sup>1</sup> may be experiencing recovery because he is **back in the job world**, another person may be working toward a different, but no less important, recovery goal. Mary illustrated this very well with her story:

**... [A]fter being homeless for so long I finally live in my own apartment. I have completed the Peer Support Specialist certification and I want to help other moms, but I will be recovered the day I get back custody of my kids.**

Peer and family members were very clear in describing recovery as when an individual has **ownership, control** and is **accountable** for their journey. Recovery also can be described as **living life without addiction, being symptom free or when the individual manages the mental illness** or as simply stated by a peer who attended a focus group **controlling the illness rather than the illness controlling us**.

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<sup>1</sup> Names have been changed to safeguard the true identity of the focus group participants

Another element of recovery emphasized by peer and family members is **community integration** within a social and personal context. Within the social context, recovery means being accepted by the community at large. Being involved in **social activities such as sports events or volunteer projects, knowing that they are welcomed and safe**, is important. The personal context of recovery **entails building personal support systems** that are **trustworthy** and **regaining or restoring family relationships** that were either broken or lost due to behavior brought on by mental illness.

## **B. Individual**

The term “Individual” captures the unique needs of all persons who live with serious mental illness. During the focus group sessions, peers and family members repeatedly emphasized that each person has distinct goals for the different aspects of his or her life. The overwhelming themes that were repeatedly expressed are best described as: Respect, Choice and Support.

### **1. Respect**

The value of respect for peers and family members cannot be understated; everyone has the right to feel **respected**. Respect was described as showing simple social courtesy during personal interaction. For example, **eye contact, being attentive to them, acknowledging their presence, being valued as a person** and **recognizing their culture and religion** were verbalized as indicators of respect. As one member noted, respect means, **to be treated like a human being**.

### **2. Choice**

A peer captured the concept of choice by stating, **we want to choose what works better for us**. Choice is significant for peer and family members because it means they have **ownership** of their **treatment** and of their **recovery journey**. When given choice, it helps **them take care of** their **needs** and allows them **to be in control**; or as one peer stated, **you are in the driver's seat**. Peer and family members believe choice is given when they are **provided with appropriate** and **accurate information** regarding **symptoms, illness, treatment, services** and **medication** in order to **make informed decisions** about their care and recovery.

### **3. Support**

Peer and family members seek support from their **friends, family members, peers, service providers** and the **community**. Overall support was described as **guidance, encouragement, encouraging action, being heard, motivation, hope** and **acceptance**. Support from peers includes **assistance in building networks, being helpful** and **sharing information about resources**. Support from the community was noted as being **connected to the community, feeling safe around people**, and **knowing neighbors**. During a discussion about what support from neighbors means, a young man proudly shared his experience:

*When I first moved to where I live, no one talked to me. When people saw me coming, they would cross the street. I knew they were afraid of me. So I went and knocked at their doors, introduced myself, explained my mental illness and apologized for scaring them. Now they don't cross the street, and some neighbors greet me by my name.*

### C. System

Peer and family members want a system that is best described in three categories: individualized care, supportive services, and integrated health:

#### 1. Individualized Care

Peer and family members made it clear that ***not everyone is the same***. Over and over, peer and family members reinforced the notion that each person has ***different recovery goals***; consequently they want a system that gives the individual, as one peer stated, ***the ability to get the treatment that fits you*** or in other words, a system that offers individualized care.

Individualized care is an ***individual's personal*** roadmap to ***recovery***. It includes ***identifying goals*** that an individual believes are important to ***improve their quality of life***. It offers a ***treatment and recovery plan*** that is designed by the individual to ***meet*** his or her ***goals***. Individualized care ***encourages*** the participation of the individual and ***honors*** his or her ***right to accept, decline*** or modify the ***recovery plan*** and the ***services*** to meet recovery goals.

Individualized care requires service providers to be ***informed*** about ***medical advances*** and to ***establish a relationship*** with all members they serve. Relationship means ***to know their story, their progress, keeping records up to date and, discussing options with the individual to meet recovery goals***.

A unique feature of individualized care identified by peer and family members is ***advocacy***. Advocacy is defined as the ***presence*** of an ***individual's voice*** while planning and living through the ***recovery journey***. It means creating ***partnership*** with the individual, in which he or she ***feels safe*** and ***supported*** to freely ***express an opinion*** that will be ***heard*** and ***discussed***.

#### 2. Supportive Services

Peer and family members want supportive services located at easily ***accessible sites*** and ***available at all times*** to help meet their recovery goals. They want supportive services, which are readily ***available in the community*** and in ***natural environments***, such as where ***they live, in their homes and schools*** or at other locations they visit frequently, such as ***clinics, health clinics, community centers and churches***.

Peer and family members clearly identified five categories of supportive services necessary for recovery: peer support services, community based resources, living arrangements, transportation and crisis services.

### 3. Peer Support Services

Peer support services are vital because peers are uniquely qualified **to listen, help and offer hope** to one another in way that professionals cannot. Two participants expressed their need for peer support by saying **they know what it is to be out there and we need someone who has been there; someone who understands what we are going through and who can tell us what to expect**. They described peer support services as **peer systems, peer centers or peer connection drop in centers and 12 step programs** such as **Alcoholic Anonymous**.

### 4. Community Based Resources

Peer and family members expressed a desire to have access to a broad range of resources available in their community in order to meet many different recovery goals. Some examples include **food boxes, food stamps, clothing, and shelter** to meet basic need goals. Others identified **life skills workshops; employment and vocational training; financial support; recreational** activities like **art and dance lessons** to meet more advanced recovery goals.

Peer and family members also want community based resources designed to improve health such as **nutrition** and **wellness education** and **physical exercise** and services that support their spiritual development such as **churches** or **faith based programs**.

### 5. Living Arrangements

Because each person has different goals, the shelter or individual living arrangement varies from peer to peer. While one peer may seek a **safe place to sleep** for a **couple of hours**, another peer may be looking to relocate to a new community. Therefore, peer and family members stated they want **options for shelter and living arrangements** that includes **transitional homes, group homes, shelters, apartments and houses**.

### 6. Transportation

Peer and family members want access to **public transportation** such as **dial a ride, bus passes, taxis and other means of transportation** that allows the individual **to access services and to engage in community activities**.

### 7. Crisis Services

Crisis services were described as services that **address, alleviate, solve and manage the unique needs** of an individual who is experiencing a **crisis or emergency**. The following are some of the crisis services that peer and family members identified: **twenty four hour (24) crisis phone lines, warm lines, hotlines, crisis counselors, crisis centers and mobile crisis teams**.

## 8. Integrated Health Services

Peer and family members are very aware of the importance of integrating physical and behavioral health care. They want a service delivery system in which **mental health providers, physical health providers and community based resource providers work together** and with the **individual** to achieve their **recovery goals**. They expect **providers to be informed of their patients' goals** and to be **knowledgeable of current medical practices and of the community based resources that are available**. The integrated health services model that peer and family members want has two distinct elements: treatment services, and care management.

### a. Treatment

Peer and family members defined treatment in the context of integrated health care as the process by which the **physical and psychological goals** of an **individual are identified** and a **recovery plan is outlined**. It includes both a **physical health and psychological assessment** and an **explanation of available service options**, such as **medication, counseling, prevention services, transitional services**, and others. Treatment is also about **monitoring** the individual's overall **progress** through **lab results** and **goal achievement**.

An important element of treatment is overall health education. Peer and family members stressed the importance of health education; they want to **understand** the **illness** or **illnesses** that affect them and **how the treatment impacts** their overall **health** so they can make **informed decisions**.

### b. Care Management

Care management is the process that **links the individual to the services** that he or she needs to **achieve** their **personal goals** during the **recovery journey**. Peer and family members described care management as **coordination of services** and the exchange of **information between health care providers**.

Care management has a dual purpose: to **coordinate and arrange those services necessary** for recovery and to **monitor service delivery** and **recovery goals** or outcomes.

Coordination of services refers to **scheduling appointments, timely exchange of medical** information such as **test results, medication, treatment plans** between **service providers** and the **individuals**. Coordination also includes **referring and linking** the individual to **community based resources** they need to meet recovery goals. The care management **monitoring** function is the process of **tracking** and **verifying** that the services **are provided** to the individual and **holding the individual accountable for meeting recovery goals**.

### **III. Final Comments**

The active participation of peers and family members in the planning, organizing, leading and monitoring of the RYV initiative has been an extraordinary learning experience for ADHS/DBHS. By sharing this information, ADHS/DBHS wants all system stakeholders to learn from it and build upon the important ideas, concepts and beliefs expressed by focus group participants in order to make the behavioral health system stronger and more responsive to peer and family member concerns.

Based on this experience, now more than ever, ADHS/DBHS remains committed to working closely with peers and family members and looks forward to collaborating with the community in other projects like this one.

If you would like to learn more about this project please contact the ADHS/DBHS Office of Individuals and Family Affairs at: Toll free (877) 464-1015 or visit <http://www.azdhs.gov/bhs/transform.htm>



# ATTACHMENT A

## Division of Behavioral Health Services

### SMI System Transformation Focus Groups Protocol

#### Facilitator Instructions

##### **Introductions: (5 minutes)**

Good (morning/afternoon), my name is \_\_\_\_\_ (Describe your position and affiliation and a brief summary of your involvement with behavioral health)

Thank you for attending this focus group session. I will serve as the facilitator for this meeting and would like to introduce to you to the others that will be assisting:

- a. Name and position, will serve as an assistant during the meeting.
- b. Name and position, will serve as a note taker.

##### **Housekeeping items: (5 minutes)**

Before we begin the meeting, I would like to go over a few housekeeping items:

1. Let the participants know where the restrooms are located.
2. Let the participants know if drinks and food are allowed in the meeting room.
3. Ask the participants to turn off or mute their cell phones.
4. Ask all the participants to sign in.
5. Distribute the agenda.

##### **Purpose of the Focus Groups: (5 minutes)**

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), wants members' collective opinion about the publicly funded behavioral health system and the services it offers to determine what is critical or valuable in

meeting members' needs. This information will be used to make recommendations and improvements to the system during the next year to year and a half in order to better serve adults with a serious mental illness.

It is important to remember that ADHS/DBHS has a specific process in place to address grievances and complaints for individual cases. ADHS/DBHS takes all complaints seriously and encourages you to use the appropriate channels to make a complaint or file a grievance. Therefore, we cannot use the limited time set aside for this meeting to address or discuss complaints or grievances in individual cases. **(Point out the contact information)**

### **Focus Group Protocol:**

After reading the purpose of the focus group, the facilitator shall: (5 minutes)

- Divide the attendees into teams of 6-8 members.
- Ask each team to identify a scribe, a speaker, and to select a name for their group.
- Provide each team with the list of questions. (Each team member shall be provided with the questions, note pad and markers)
- Read the ground rules.

### **Ground rules:**

ADHS/DBHS is interested in knowing what each of you thinks, so please be frank and share your point of view, keeping in mind the following:

1. There are no right or wrong answers, only each person's point of view and opinions and it is very important that we respect each other's contributions.
2. We're on a first name basis.
3. Please remember to turn off or mute cellular phones and pagers.
4. The facilitator's role is to:
  - a. address questions,

- b. provide each group with information related to the questions,
- c. conduct the meeting according to the protocol, and
- d. keep track of time to make sure each group answers every question.

**Individual Group Activities: (60 minutes)**

1. Read each question to the teams and clarify any questions the attendees may have.
2. Instruct the scribes to write the answers to the questions on the note pad provided to their team.
3. The scribes shall label the answer to each question , with the number of the questions as follows:
  - a. **Q 2**, for question # 2, **Q 2 a** for question # 2 a, and so forth.
  - b. If more than one sheet of paper is needed for one question, the additional sheets s shall be labeled Q-2-1, Q-2-2 and so forth.
4. The scribe shall draw a line to separate the responses between questions.

**Questions:**

1. Describe the services you want:
2. Describe the relationship you expect from the clinical team:
  - a. What do you believe is the function of case management?
  - b. What do you believe is the function of a case manager?
  - c. What do you believe is the function of the doctor?
  - d. What do you believe is the function of the nurse?
  - e. Describe your function on your team.
3. Describe what you believe support services are.
  - a. When and where should support services be available?
4. Describe what recovery means to you:

5. Describe what helps you to improve your living situation:
  - a. Describe what “belonging to” or “being connected to” the community means to you?
  - b. Describe how choice is important in directing your treatment.
  - c. Describe a behavioral health system that promotes its members toward graduation.
6. What rights are most important to you within the behavioral health system?
7. Do you have any additional concerns or comments you would like to share about the way the behavioral health system works?

**Group Activity: (30 minutes)**

1. Ask each group to present their answers to the rest of the groups. Clarify and validate the information presented by the team.
2. As the teams present their information, list the trends on a different sheet. The trends shall be listed on a different sheet. Label the upper right corner of each sheet, as follows T Q 1, if more than one sheet of paper is needed the shall label TQ-1-1, TQ-1-2 and so forth.

**Closure: 10 minutes**

**Explain to the participants that ADHS/DBHS will continue to gather community input until xxx date and that the results will be available at the following web address [www.azdhs/bhs.gov](http://www.azdhs/bhs.gov)**

**Closing Remarks:**

**On behalf of ADHS/DBHS (and the name of clinic/agency hosting the meeting), I want to thank you for taking time to participate in this process. It has been a pleasure to work with all of you!!!**

# ATTACHMENT B

## DBHS Focus Groups Schedule

	<b>PNO<sup>(1)</sup> Location</b>	<b>Region</b>	<b>Address</b>	<b>City, ZIP</b>	<b>Phone</b>	<b>Bus Route</b>	<b>Dates</b>	<b>Event Time</b>
1	CHC Townley	North	8836 N. 23rd Ave., Ste. B-1	Phoenix, 85021	(602) 944-9810	90 (Dunlap)	10-Nov	1p - 3p
2	PIR E. Valley	East	4330 E. University Dr.	Mesa, 85205	(480) 218-3280	30 (University)	10-Nov	5p - 7p
3	PCN Capitol Center	Central	1540 W. Van Buren St.	Phoenix, 85007	(602) 252-7330	3 (Van Buren) or 15 (15th Ave)	12-Nov	1p - 3p
4	PCN Capitol Center	Central	1540 W. Van Buren St.	Phoenix, 85007	(602) 252-7330	3 (Van Buren) or 15 (15th Ave)	16-Dec	1p - 3p
5	SWN Cave Creek	North	14040 N. Cave Creek Rd., Ste. 203	Phoenix, 85022	(602) 992-9336	90 (Dunlap)	12-Nov	5p-7p
6	CHC Enclave	East	1642 S. Priest Dr., Ste. 101	Tempe, 85251	(480) 929-5100	56 (Priest)	15-Nov	1p - 3p
7	SWN Osborn	Central	3640 W. Osborn Rd., Ste. 1	Phoenix, 85019	(602) 269-5300	35 (35 <sup>th</sup> Ave.)	15-Nov	5p - 7p
8	PIR Metro	North	10240 N. 31st Ave., Ste. 200	Phoenix, 85051	(602) 997-9006	50 (Camelback)	16-Nov	10a - 12p
9	PIR West Valley	West	11361 North 99th Avenue	Peoria, 85345	(623) 523-6600	106 (Peoria Ave)	17-Dec-	2:3- 4:30 p
10	SWN West Camelback	West	5022 N. 54th Ave., Ste. 4	Glendale, 85301	(623) 931-4343	44 (44 <sup>th</sup> St.)	16-Nov	1p-3p
11	CHC Arcadia	Central	3311 N. 44th St., Ste. 100	Phoenix, 85018	(602) 957-2220	27 (27 <sup>th</sup> Ave.)	16-Nov	5p - 7p
12	CHC Arcadia	Central	3311 N. 44th St., Ste. 100	Phoenix, 85018	(602) 957-2220	27 (27 <sup>th</sup> Ave.)	14-Dec	2p - 4 p
13	SWN Garden Lakes	West	4170 N. 108th Ave.	Phoenix, 85037	(623) 932-6950	41 (Indian School)	17-Nov	5p-7p
14	SWN, San Tan Clinic	East	1465 W. Chandler Blv.,	Chandler, 85224	(480) 786-8200	156 (Chandler Blv)	15-Dec	2p - 4 p
	<b>Peer-Run</b>	<b>Region</b>	<b>Address</b>	<b>City, State, ZIP</b>	<b>Phone</b>	<b>Bus Route</b>	<b>Dates</b>	<b>Event Time</b>
15	STAR East	East	340 W. University, Ste.19	Mesa, 85201	(480) 649-3642	30 (University) or 112 (Country Club)	17-Nov	10a - 12p
16	North Phoenix Visions of Hope	North	601 W. Hatcher	Phoenix, 85021	(602) 404-1555	106 (Peoria)	17-Nov	1p - 3p
17	CHEEERS	Central	950 W. Heatherbrae Dr., Ste. 5	Phoenix, 85015	(602) 246-7607	8 (7 <sup>th</sup> Ave.)	18-Nov	5p - 7p
18	STAR West	West	605 N. Central Ave.	Avondale, 85323	(623) 932-2735	560 (Avondale)	19-Nov	1p-3p

	Greater Arizona	Region	Address	City, State, ZIP	Phone			
19	Fairfield Inn & Suites Sierra Vista. Mountain View Room	Sierra Vista	3855 El Mercado Loop, Sierra Vista	Sierra Vista, 85635	(520) 439-5900		16-Nov	3:30 - 6:00 P
20	CPSA Training Plaza	Tucson	2502 N. Dodge Boulevard, Ste 130	Tucson, 85716	(520) 325 - 4268		19-Nov	1p - 3:30p
21	City Hall	Casa Grande	510 East Florence Blvd., 85122	Casa Grande, 85122	(520) 421 - 8600		18-Nov	1p - 3:00p
22	The Empowerment Center	Payson	107 East Aero Drive	Payson, 85541	(928) 474-2668		16-Nov	4:30 p - 6:30p
23	The Living Center	Yuma	1444 S 4th Avenue	Yuma, 85364	(928) 261-8668		19-Nov	10a- 12-p
24	Recovery Journey House	Casa Grande	312 E. 3rd St.	Casa Grande, 85122			17-Dec	10 a - Noon
25	Serenity Circle	Cottonwood	1229 E. Cherry St.	Cottonwood, 86326	(928) 634-1168		8-Dec	5:30 p - 7:30 p
26	New Hope Recovery Center	Prescott	559 White Spar Road, 86303	Prescott,	(520) 459-2624		1-Dec	5:30 p - 7:30 p

(1) Provider Network Organization

# ATTACHMENT C

***“RAISE YOUR VOICE”***

***FOCUS GROUPS***

***CATEGORY QUESTIONS DEFINITIONS***

## **Category Definitions:**

### **Question 1: *Describe the services you want.***

#### **Recovery Oriented Services:**

##### **Community Based Resources-**

Responses relate to rehabilitation and social supports for behavioral health recipients. Rehabilitation includes: living skills, health promotion, vocational supports, training, education, employment. Social interactions include: community, activities, excursions, physical exercise, and group/social events.

##### **Living Arrangements-**

Responses relate to housing: homes, apartments, group homes, safety/quality of living environments and housing services provided.

##### **Support-**

Responses include: family, peer, and friend supports. Other types of support included: transportation and respite care.

##### **Treatment-**

Responses include: counseling, prevention, therapy, and transitional services.

#### **Systemic Administration:**

Responses relate to: AHCCCS, agencies, facilities, hospitals, eligibility, access, Non Title 19, Title 19, availability, funding, appointments, benefits, and communication/assistance with these processes.

#### **Care Management:**

Responses concerning behavioral health processes within the clinic; case management, continuity of care, coordination of crisis services and management processes. Behavioral health staff including; doctors, nurses, case managers, counselors, clinical teams etc.

#### **Recovery Approach:**

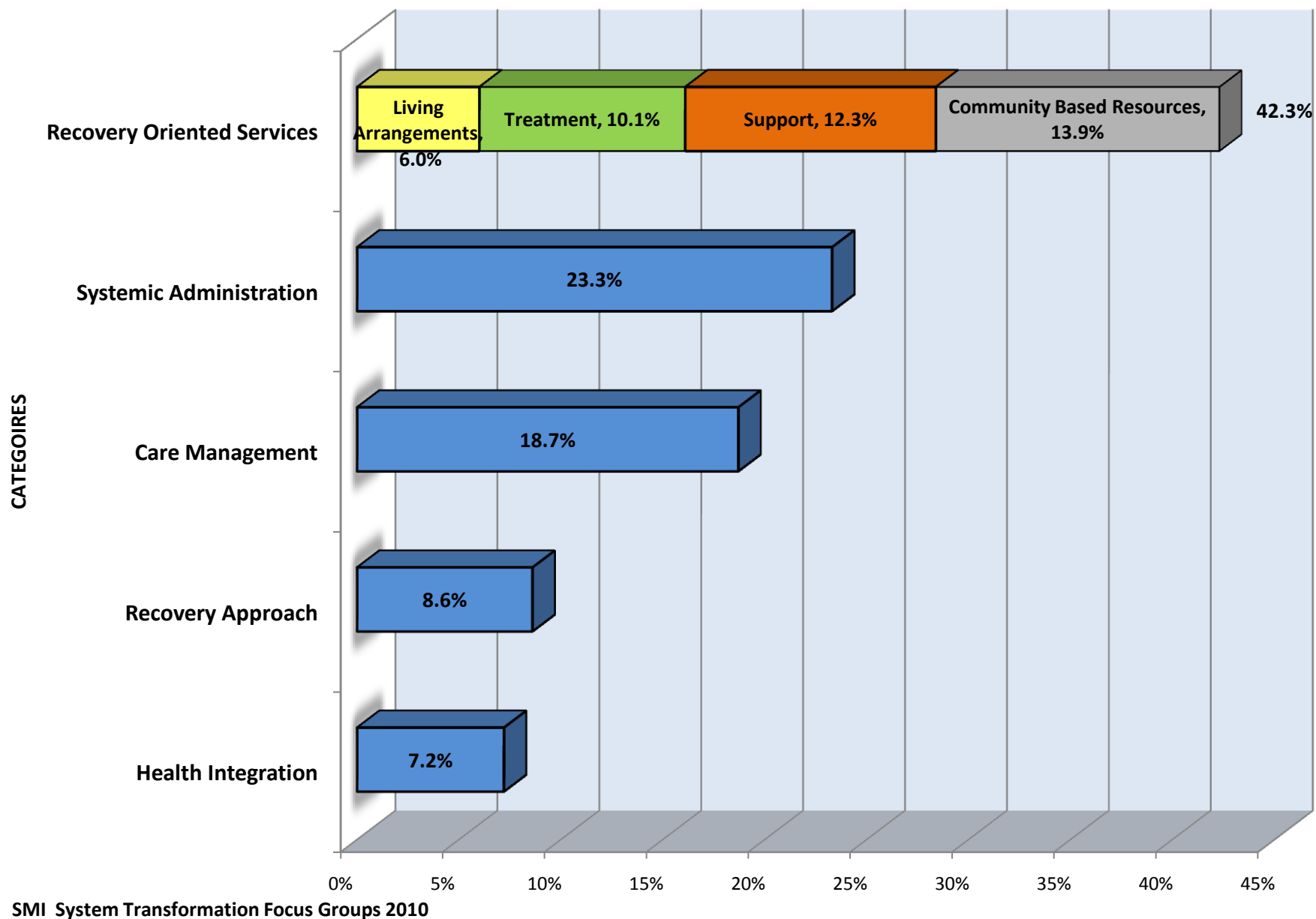
Responses are specific to the client, individual, patient, recipient, person, consumer etc...This includes: empowerment, advocacy, diagnosis and the voice of the individual with behavioral health systems and responses specific to recovery language.

#### **Health Integration:**

Specifically relates to medication responses. For example: medical management, medications, medication monitoring, medical attention, and prescriptions. This includes: coordination of care and physical care medical needs.



## Question 1: Describe the services you want



## **Question 2: *Describe the relationship you expect from the clinical team.***

### **Professional:**

Responses relate to professionalism: responding to calls and questions, overall communication, expertise/education of staff. Included is supporting, tracking and follow-up of clients. Time: more time with staff, more one on one time with counselor, more time to discuss all aspects of treatment, more time to analyze needs and overall more efficiency.

### **Respect:**

Responses include treating clients with respect: respecting the individual and being open and receptive to client's needs. Compassion: to care, be understanding, be helpful, and attentive to client. Friendly: be friendly with clients, have a relationship with the team, to be friends, to care and have friendships.

### **Community Based Resources:**

Responses include awareness of connecting to resources, help, and options to services for example, employment, respite, outreach, residential, peer support, and transitional supports.

### **Supportive:**

Responses are specific to support: support in everything, in recovery, providing guidance, peer support and to be more involved in a "hands on approach".

### **Case Management:**

Responses concerning case management services: coordinating services, collaborating with client, knowledge of client, representation of client, making referrals and continuity of care.

### **Stability:**

Responses relate to having stability in staff: maintain stability, being dependable, availability, consistent personnel and less turnover of staff. Included is the idea of trusting staff and not liking starting over with different staff.

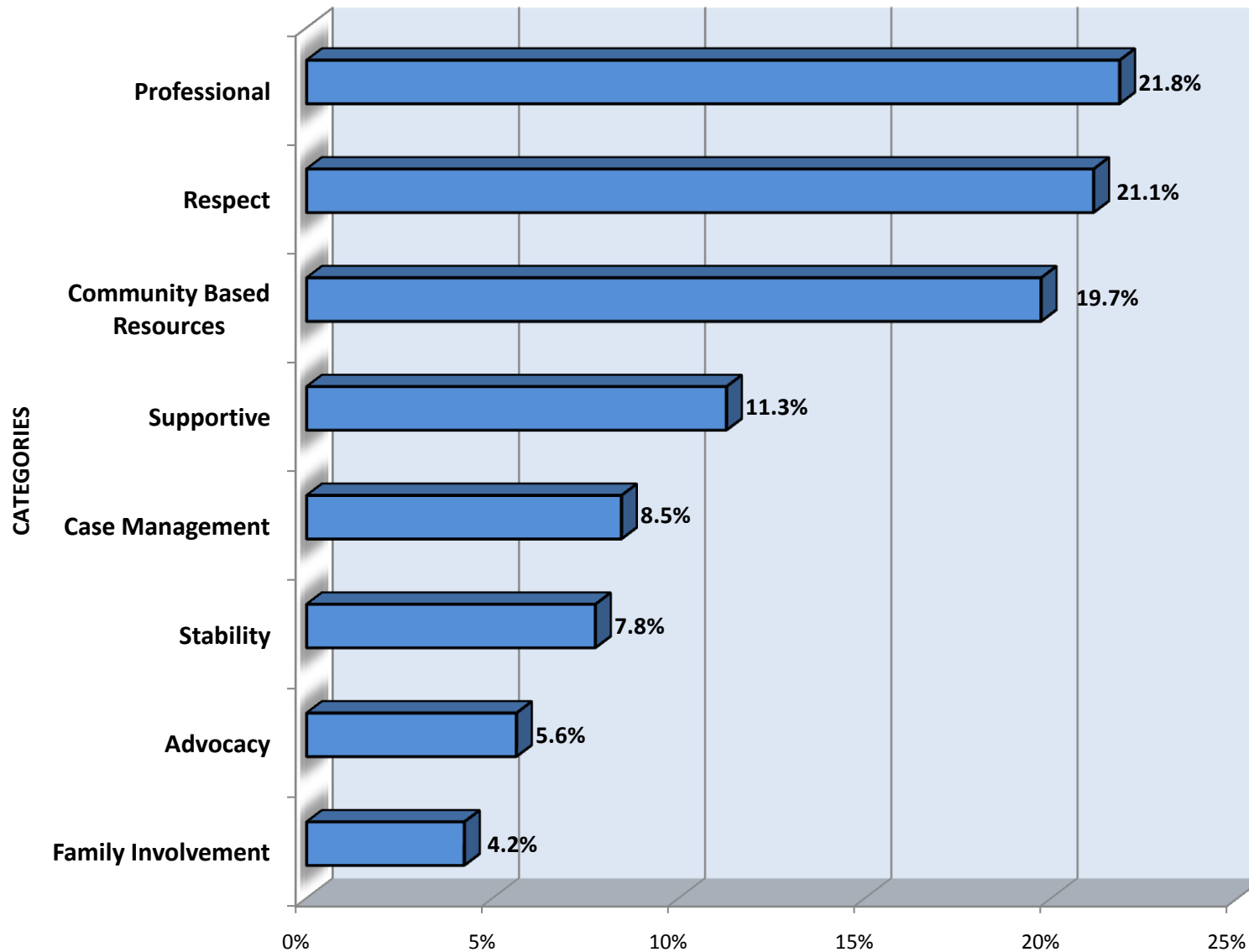
### **Advocacy:**

Responses relate to advocating for the client: have a partnership, being proactive, providing help based on needs.

### **Family Involvement:**

Responses include having family involved in treatment: family involved with case management, collaborate with family, and be open and receptive to family's needs.

## Question 2: Describe the relationship you expect from the clinical team



SMI System Transformation Focus Groups 2010

## **Question 2a: *What do you believe is the function of case management?***

### **Coordinate Care:**

Responses include various aspects of coordinating care: help with medication, treatment plans, find and manage service delivery, consult with others/providers/agencies, tie it together, help with our needs, bridge to services, help set-up appointments and goal setting. Included: be a guide, be a gatekeeper, and overseer.

### **Community Based Resources:**

Responses relate to helping find, linking to and referring to resources. Resources include: food boxes, life skills, housing, employment, transportation, bus passes, schools, vocational training, nutrition assistance, community resources, and social security benefits. Knowledgeable of Services; have staff aware of services and tell me what's available to me. Educate about services, supports, and options available. For examples, schools, housing, counseling, transition, treatment homes, doctors, vocation rehabilitation, and nursing.

### **Communication:**

Responses include communication to client: better/ clear communication, listening, outreach, follow-up with client, responding to calls, checking on client, better feedback, keeping client informed, emergency contact, and voicemail returns.

### **Supportive:**

Responses include offering support to clients and families: providing guidance, mentoring, coaching, taking interest in client, be there 24/7, ability to ask questions when needed, and show more concern.

### **Professional:**

Responses relate to professionalism: be organized, respectful, skills, have the right information, timely services, honesty, trust, efficiency, be on time, better attitudes, and accountability.

### **Individualized Care:**

Responses include providing clients with individualized treatment: meet individual needs, help with what you need, evaluation of individual and self-sufficiency.

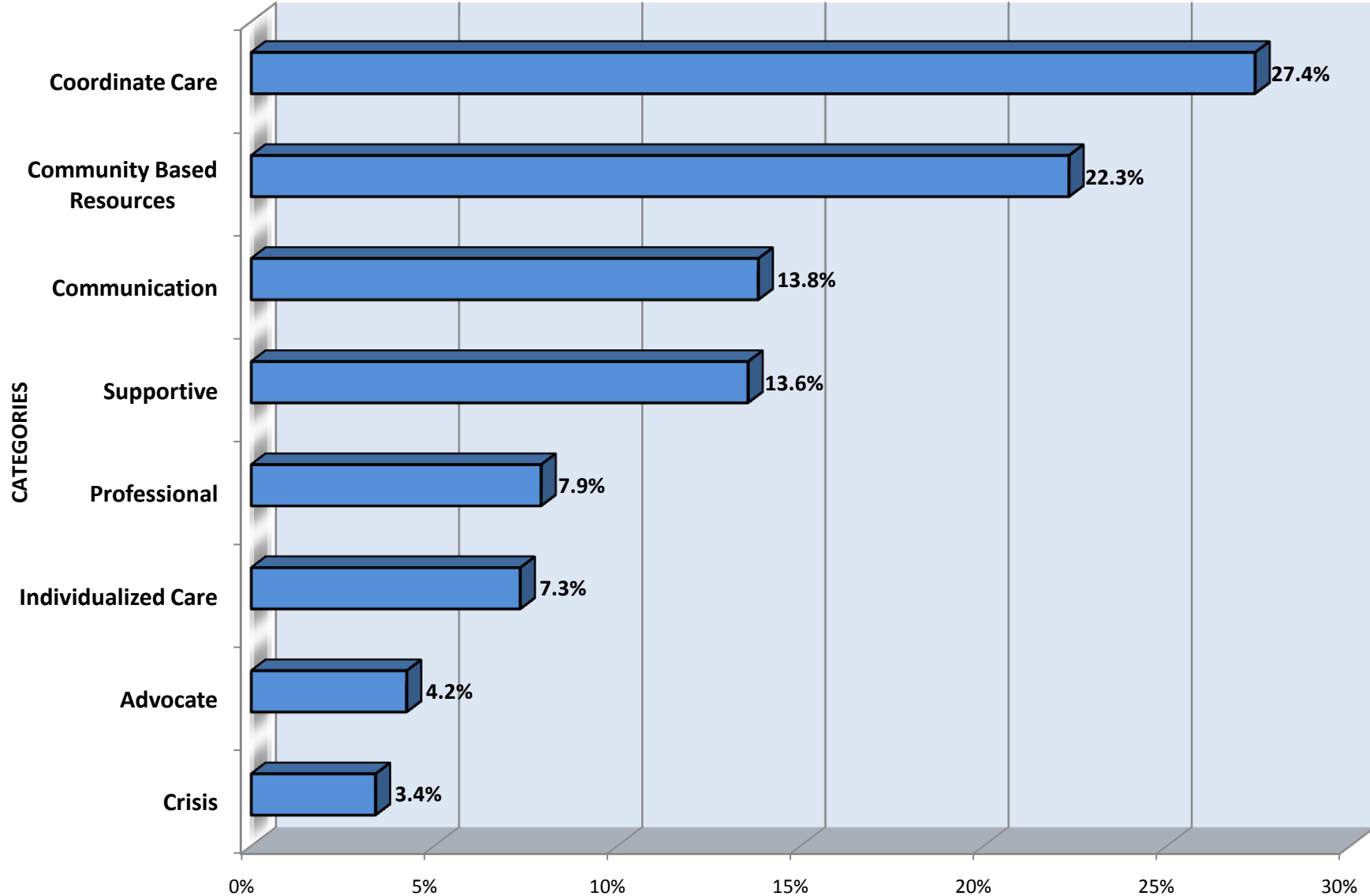
### **Advocate:**

Responses relate to advocating for the client: liaison for rest of team/outside community, partners with client, and run interference for client.

### **Crisis:**

Responses are specific to crisis situations: crisis prevention/aversion/management, respond in case of emergency, alleviate crisis, be available, and solving crisis situations.

### Question 2a: What do you believe is the function of case management?



SMI System Transformation Focus Groups 2010

## **Question 2b: *What do you believe is the function of a case manager?***

### **Coordinate Care:**

Responses relate to various aspects of coordinating care: assist with all needs, gatekeeper, assistance with medications, schedule appointments with doctors, help in crisis, set-up therapy, help with treatment plans, transition, oversees care, and the liaison between client and services.

### **Community Based Resources:**

Responses relate to helping find, linking to and referring to resources. Resources include: food boxes, transportation, housing, utilities, nutrition assistance, vocational education trainings, community resources, assist to apply for social security, and help with meeting basic needs. Knowledgeable of Services: staff aware of what services are available, informed staff, educated about services, understanding eligibility, and pass this knowledge to clients.

### **Professional:**

Responses relate to professionalism: have up to date trainings, respond in a timely manner, keep track of clinical records, track progress, be organized, be honest, have good manners, review client file prior to visit, accountability, patience, and report to clinical team. Time: having time with case manager and counselor, more quality time, provide timely help and more interaction with case manager.

### **Supportive:**

Responses are specific to offering support to clients: personal relationships, be a friend, be a confidant, be a mentor, be compassionate, be caring, provide guidance, include natural supports (family and friends), and visit clients in the hospital.

### **Communication:**

Responses include communication to client: good/clear communication, effective listening, follow-up, with weekly communications, provide better input, share information with client, and communicate between client, family, and agencies.

### **Individualized Care:**

Responses are specific to providing clients with individualized treatment: more one on one contact, take care of case as an individual, know client's strengths, individualized services, and ensure needs are met.

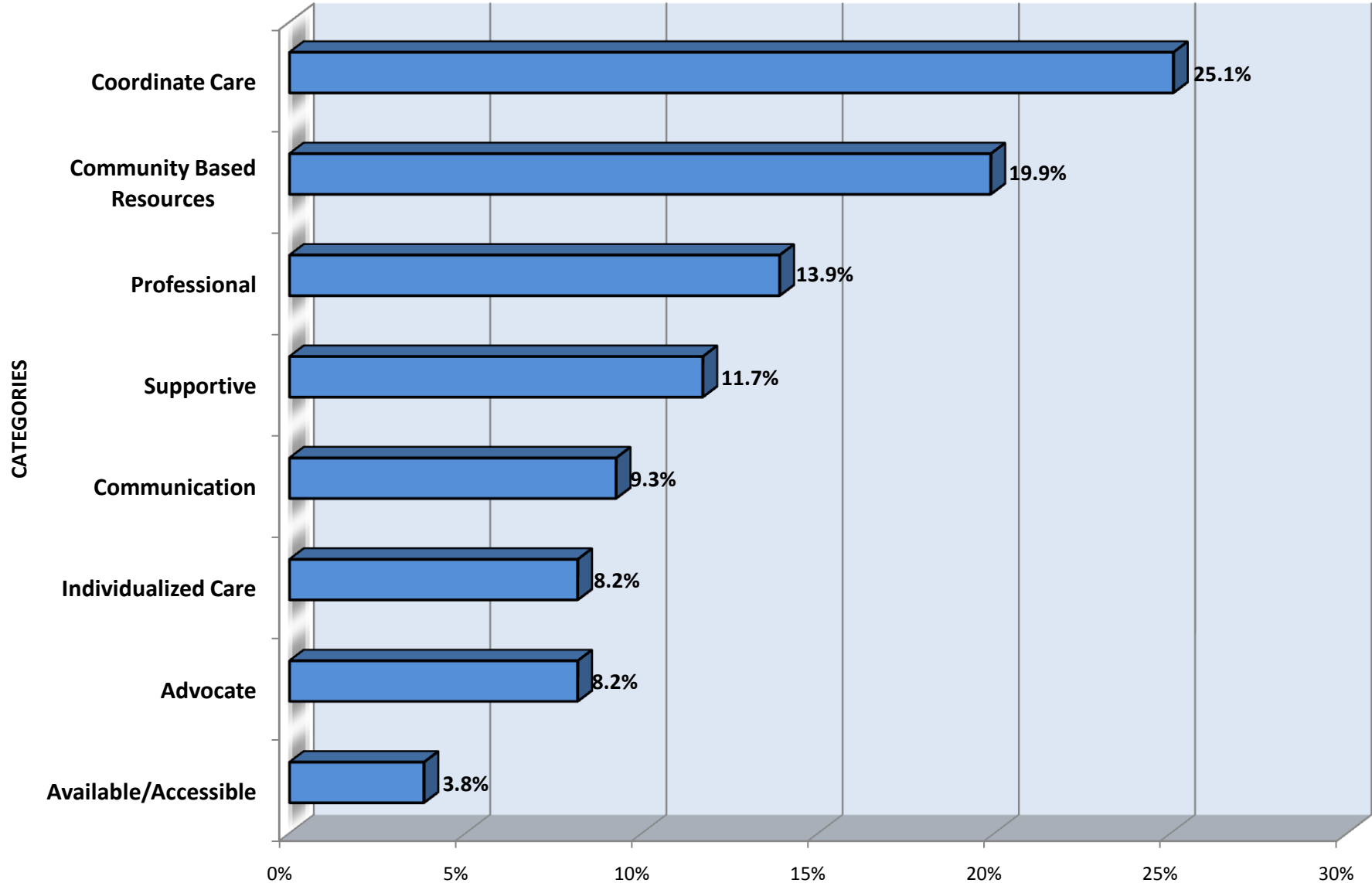
### **Advocate:**

Responses relate to advocating for the client: take care of client, partner with client, be an inter mediator, be dedicated and empower client.

### **Available/Accessible:**

Responses relate to having the case manager be available and accessible to client: be there for client when needed, assistance on weekends, have a back up as needed and access to personnel versus calling the crisis line.

## Question 2b: What do you believe is the function of a case manager?



SMI System Transformation Focus Groups 2010

## **Question 2c: *What do you believe is the function of the doctor?***

### **Medication Management:**

Responses are specific to various aspects of medication management: prescribing, providing, monitoring, managing, and adjusting medications. Included is ensuring proper/appropriate medication, explaining/monitoring for side effects, drug interaction education, medication evaluation, and asking how client feels on medication.

### **Treatment:**

Responses relate to providing medical treatment: monitor blood levels, labs/test results, do health assessments, evaluations, ISP reviews and psychological evaluations. Diagnosis and the doctor: do accurately, properly, and give the right diagnosis.

### **Communication:**

Responses include communication to client: listen to client, listen for symptoms, answer all questions, address issues, and communicate with case manager, RBHA, nurse and clinical team.

### **Compassion:**

Responses are specific to doctor having compassion for patient: have empathy, care, people skills, personable, respectful, considerate, make client comfortable, develop a trust relationship, make eye contact, do not rush client out, and to heal not harm.

### **Professional:**

Responses include the doctor's professionalism: have a consistent doctor, less turnover, be accessible/available, keep appointments, have regular appointments, have medical knowledge and informed on medical advances.

### **Individualized Care:**

Responses relate to having doctors focus on patient: treatment is customized to individual, research patient's background and history, give personal attention, and discuss whole person.

### **Time/Visits:**

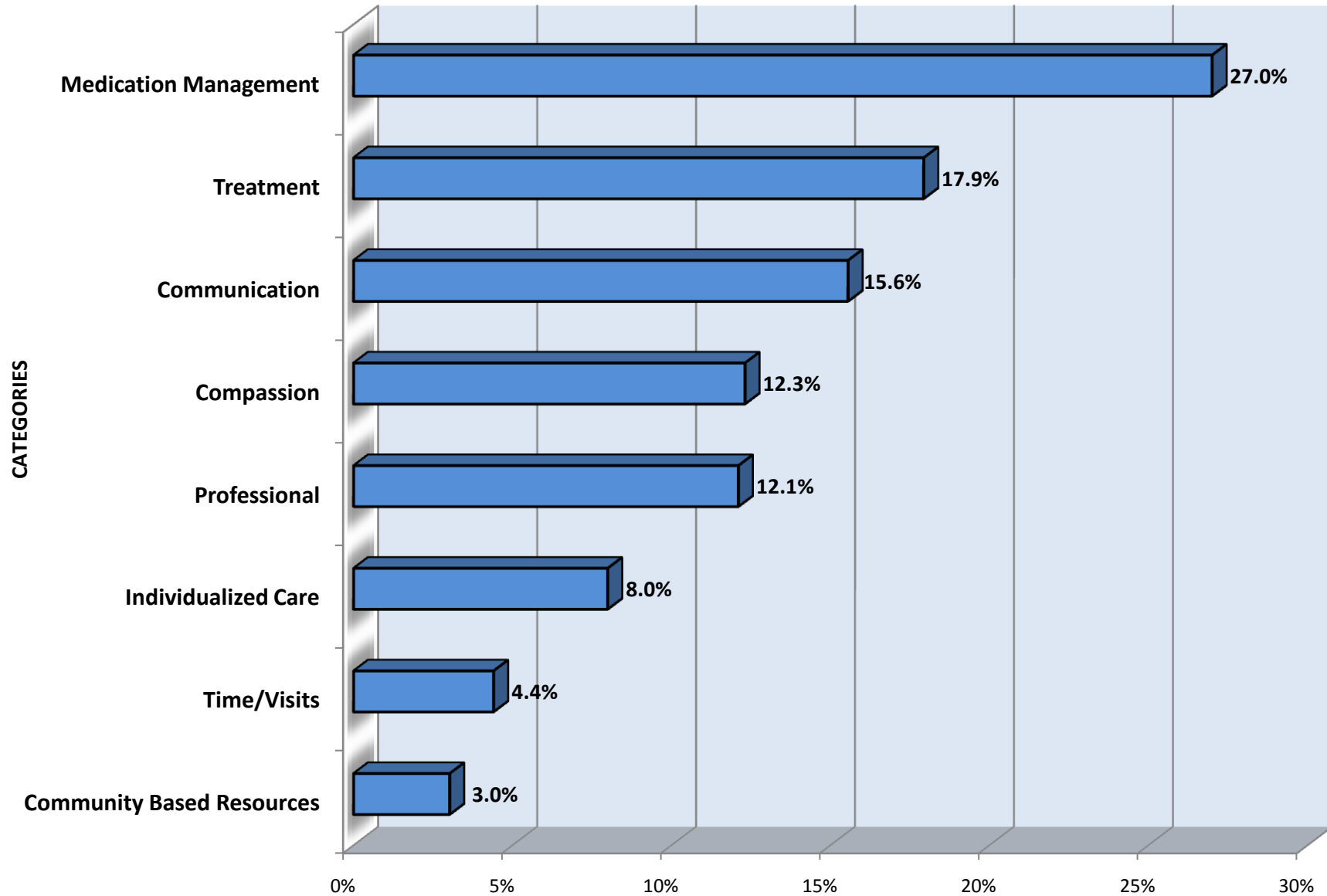
Responses include spending more time/visits with clients: have monthly visits with doctor, increase frequency of visits and overall more one to one time.

### **Community Based Resources:**

Responses relate to doctor's awareness, connection, and linking of resources. Resources include: help get SSI, nutrition education, and consideration of options for medication and alternative treatments.



### Question 2c: What do you believe is the function of the doctor?



SMI System Transformation Focus Groups 2010

## **Question 2d: *What do you believe is the function of the nurse?***

### **Health Assessment:**

Responses are specific to providing physical health assessment to clients: checking health, wellness checks, physical check-ups, annual physical assessments, prescreening for doctors and medical care between doctor appointments. Labs: having nurses perform various lab services, take/draw blood, give shots/injections, take/monitor vitals, check blood pressure, temperature, weight, and monitoring of lab results/work.

### **Medication Assistance:**

Responses relate to medication assistance with clients: educate clients on medications, monitor/handle/dispense medications, evaluate/monitor side effects, watch for medication interactions, provide clear medication information, answer medication questions, help with refills, and pharmacy intervention if needed.

### **Liaison to Doctor:**

Responses include having nurse act as liaison to doctor: communicates with doctor, interface with doctor, tell doctor patient's concerns/questions, share patient information with doctor, work as a team/in tandem, relay messages to doctor, and serve as the peer/client's voice.

### **Coordinate Care:**

Responses relate to various aspects of coordinating care: make appointments, track overall health, provide continuity of care, coordinate with PCP/hospital, exchange medical records with PCP and be the line of communication between the doctor and patient.

### **Individualized Care:**

Responses are specific to the nurse being informed about the client: updated on client's health, record keeping, writing scripts, taking notes, pinpoint client's strengths/weaknesses, tracking of complaints, and overall knowledge of the patient.

### **Health Education:**

Responses include providing clients overall health education. Health education includes: encouraging healthy habits, helping with weight gain, advising/educating on exercise, nutrition, smoking cessation, diabetes, cholesterol, dietary needs, community health, and answering health related questions.

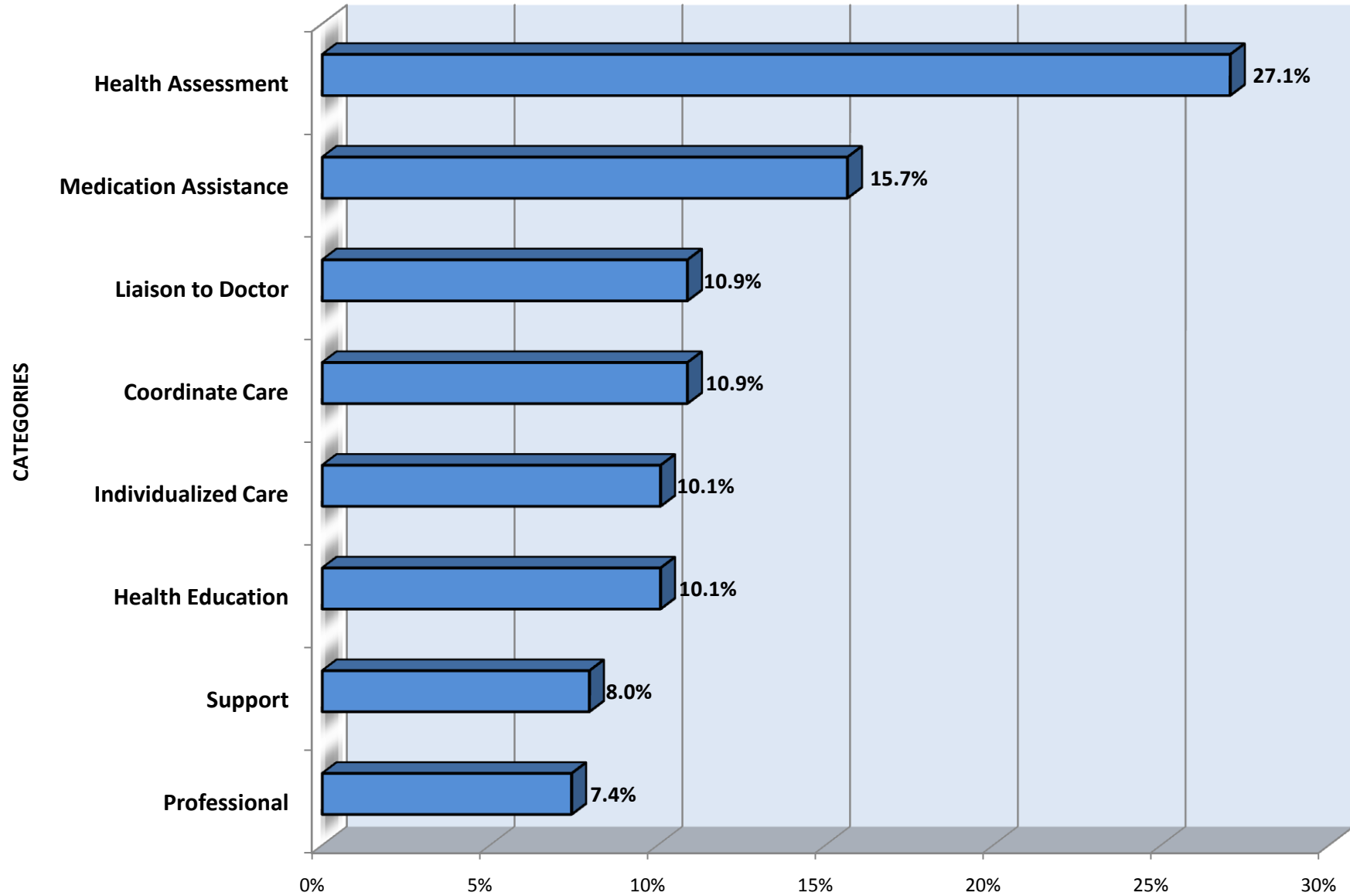
### **Supportive:**

Responses relate to the nurse as a support of the client: chat with client, provide support, show that they care, establishing personal contact, be available, encourage action taking (ex Alcoholics Anonymous and Narcotics Anonymous) and provide a humanistic approach.

### **Professional:**

Responses are specific to the nurse's professionalism: do not rush the client out, be respectful, be flexible, be educated, be certified, be timely, treat patients with dignity, know function/role, and notify client ahead of time in cases of cancellation. Listen: nurse listening to the client, listen to what we have to say, have a willingness to listen and listen to symptoms.

### Question 2d: What do you believe is the function of the nurse?



SMI System Transformation Focus Groups 2010

## **Question 2e: *Describe your function on your team.***

### **Ownership:**

#### **Ownership of Treatment-**

Responses include having the client show ownership in their treatment: accept/take responsibility, accountability, have self-advocacy, be the team leader/captain, be honest, proactive, informed, and empowered, communicate your symptoms, partner in ISP, show up for appointments, and have patient driven planning. Time: specific to timeliness, be on time for appointments, keep appointments, and show up for appointments.

#### **Team Approach-**

Responses relate to various aspects of coordinating care: working as a team, following ISP, working toward goals, medication management, medication taking, cooperation with doctor, setting appointments, discussing treatment options and ensuring services are received.

#### **Supportive-**

Responses relate to being supportive: be available, be encouraging, be dedicated, be motivated advocate, and include family as support systems.

### **Communication:**

Responses include communication of client and team: return calls, keep in contact, be honest, have input valued, have open communication at all times, and communication amongst the team. Provide Information: from client to team, report changes, share individual information, get all information, take care of files, keep track of information, and keep informed of changes in health status.

### **Treatment Planning:**

Responses relate to client and treatment planning: discuss options together, discuss different perspectives about an individuals' case, review issues, resolve issues in treatment planning, pay attention to client's progress, provide ideas of treatment options, and discuss overall well-being.

### **Community Based Resources:**

Responses relate to helping find, connecting to and referring to resources. Resources include: transportation, food handler cards, driver licenses, education, employment, volunteer services, community resources, social security cards, wellness classes, and peer support.

### **Accept Recommendations:**

Responses are specific to having client acceptance of clinical team recommendations: be cooperative, be willing, be open to suggestions, be compliant with team, follow directions, listen to what is said and follow the plan.

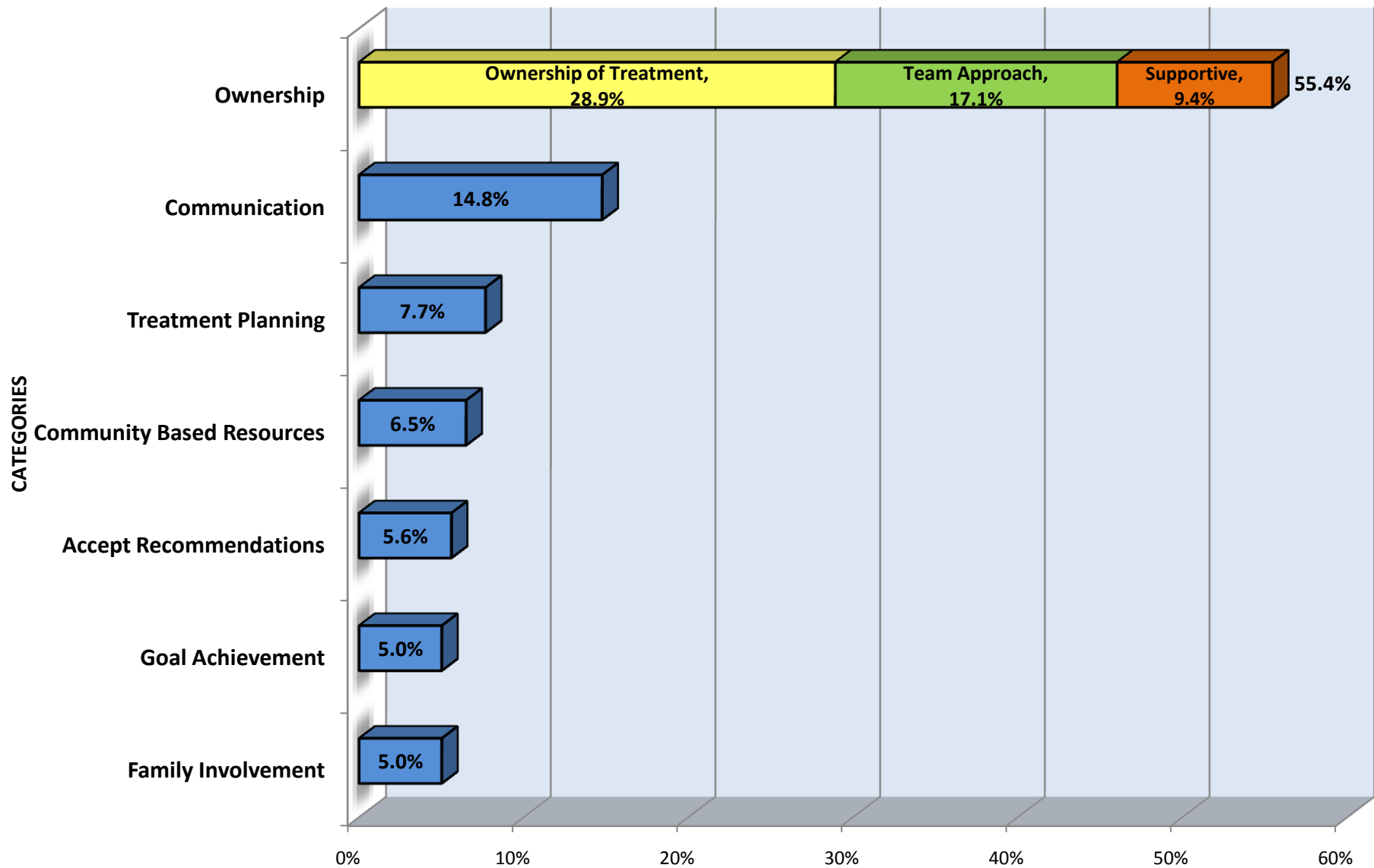
### **Goal Achievement:**

Responses relate to client's goal achievement: keep and maintain my goals, follow through on goals, work toward goals, and reach our goals.

### **Family Involvement:**

Responses include ways to have family involvement: more family involvement, advocate for family members, consider ate of family members, keep family informed, and solicit and value family input.

## Question 2e: Describe your function on your team



### **Question 3: *Describe what you believe support services are.***

#### **Community Based Resources:**

Responses relate to referrals and resources. Included: financial supports, art/dance classes, emergency services, food/food boxes, clothing, teaching tools, job trainings, employment, social activities, recreation opportunities, housing, community services, drop in centers, food stamps, day programs, psycho education and resource center. Other Support Groups: 12 step support groups, AA programs, families, churches, work supports, safety net groups and vocational rehabilitation.

#### **Peer Support:**

Responses specific to the importance of peer support: peer services, peer centers, peer connections, need of peer support, peers are helpful, networking peer system, employing peers and recovery support specialist. and recovery support specialists.

#### **Accessibility:**

Responses include access to support services: available 24 hours a day, on weekends, after hours, where needed, easily accessible, close to home, in a centralized location, mobile services, telephone access and have services listed online.

#### **Crisis:**

Responses include having crisis services availability: 24 hours a day, 7 days a week, 365 days a year, crisis/warm lines, crisis centers, crisis interventions, peer support hotlines, wherever crisis is happening, and emergency contact numbers.

#### **Treatment Services:**

Responses are specific to providing treatment services: counseling, group counseling, therapies, cognitive behavioral therapies, substance abuse treatment, respite care, and coordination from short term care facilities.

#### **Medical Services:**

Responses relate to medical services: medical checks, doctor visits, medication regulation, medication monitoring, nurse visits and additional support with doctors/hospital settings.

#### **Transportation:**

Responses are specific to the clients' need for more transportation assistance in the form of bus passes, cabs, taxis, and dial a ride, and daily transportation.

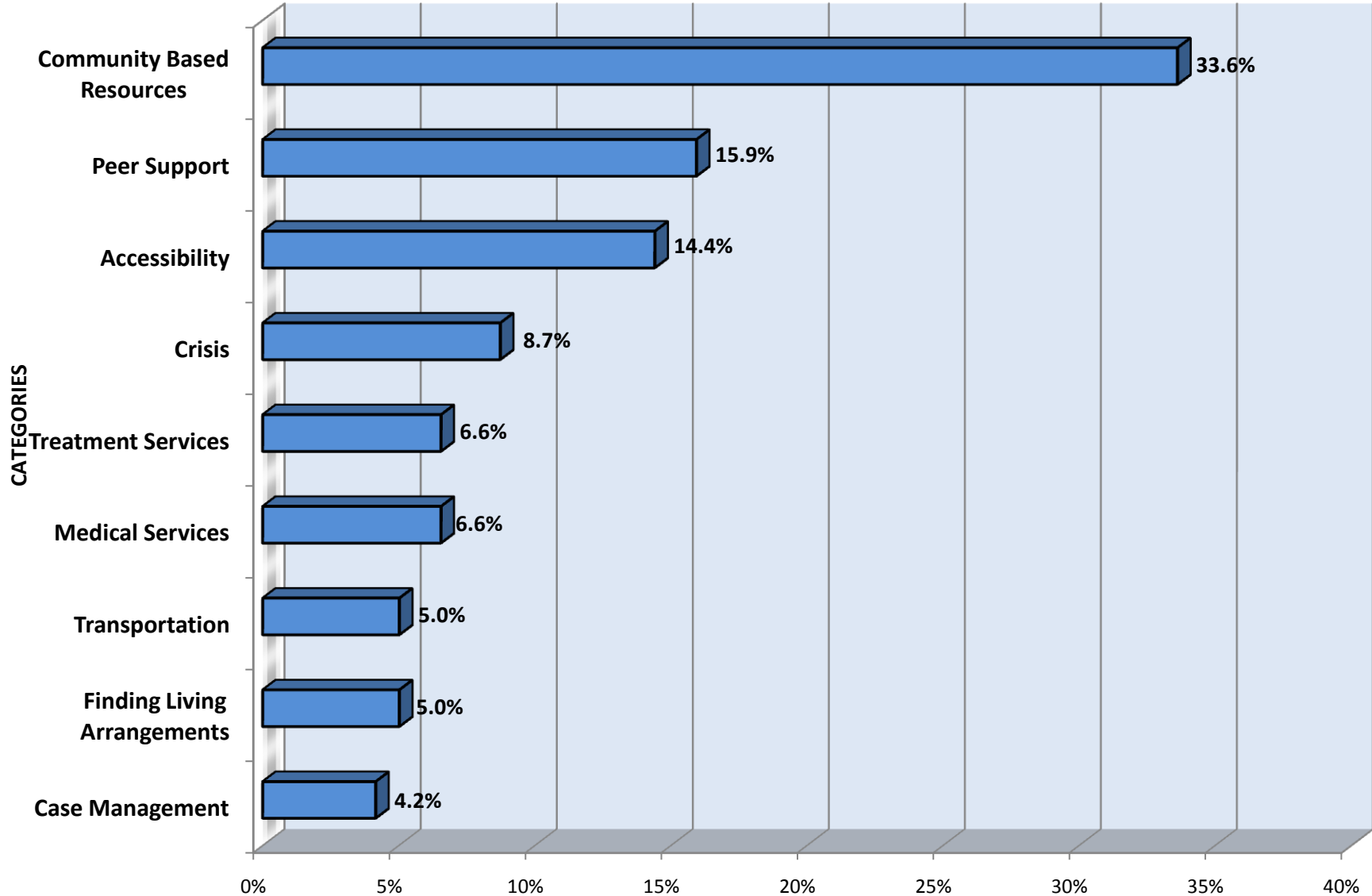
#### **Finding Living Arrangements:**

Responses relate to helping clients find housing that fits their needs.

#### **Case Management:**

Responses included case management: case managers for all participants, case managers need to be informed on what is available, and additional community based case management.

### Question 3: Describe what you believe support services are



SMI System Transformation Focus Groups 2010

### **Question 3a: *When and where should support services be available?***

#### **At All Times:**

##### **Anytime-**

Responses are specific to having services available 24 hours/7 days a week: always, anytime, at all times, around the clock, and in the form of warm/crisis lines.

##### **When Needed-**

Responses include having services available when needed: right away, based on client need, as needed, as often as necessary, as much as possible, given on demand, until graduation occurs, whenever necessary, flexible, and at a person's request.

##### **After Hours-**

Responses include services available after hours: on weekends, holidays, evenings, and night programs.

#### **Transportation:**

Responses relate to transportation needs: services during regular bus hours, transportation for everyone, mobile services, centralized location, and providing rides.

#### **Clinic/Agency/Center:**

Responses are specific to having services available at clinics/agencies/centers like: urgent care, local clinic, living center, provider agency, recovery center, health clinic, hospice, hospital, and resource center.

#### **Community & Home:**

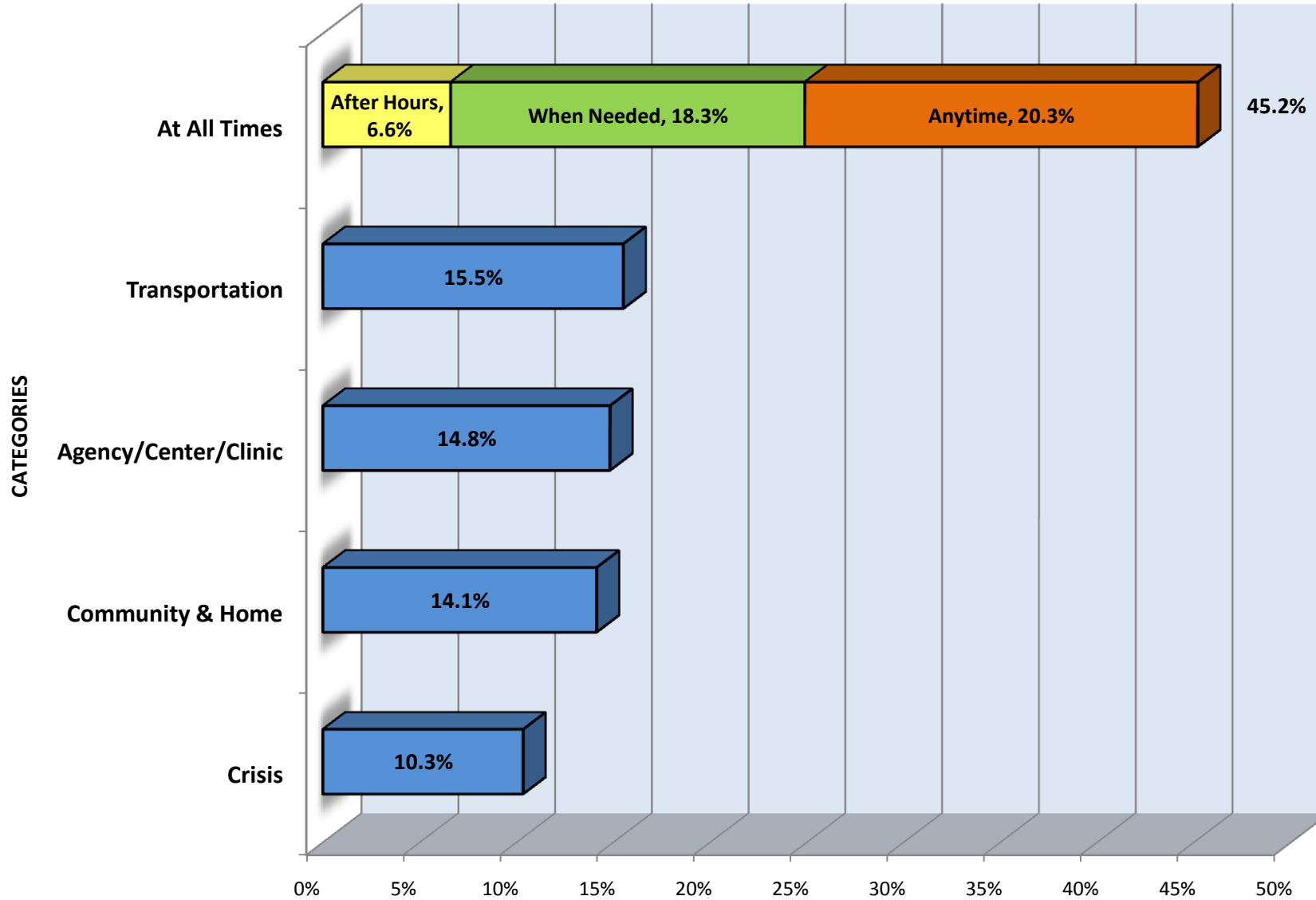
Responses relate to having services in the community and home. In the community; at school, at church, community centers, and accessible in my area. In the home; in my home, where I stay, home services, house treatment, and close to home.

#### **Crisis:**

Responses include availability of crisis services: right away in a crisis, 24 hour crisis line/warm line/hotline, crisis counselors on site, in a crisis situation, in emergency, crisis centers, and mobilized stations for crisis responses.



### Question 3a: When and where should support services be available?



SMI System Transformation Focus Groups 2010

#### **Question 4: *Describe what recovery means to you.***

##### **Quality of Life:**

Responses centered on quality of life, living life to your fullest, being able to function, live independently, being self-sufficient, productive and overall improvement/better life.

##### **Ownership:**

Responses referred to recovery being an individual process, self-defined, being accountable in your recovery, being productive, setting goals, taking control, being empowered, involved and comfortable.

##### **Community Integration:**

###### **Social Connectedness-**

Responses were related to being able to function on society, being a member of your community/society, being accepted, being connected, involved in your community, participating in social activities/groups, having friends, and developing healthy relationships.

###### **Healthy Relationships-**

Responses centered on having support in your life like family involvement, support groups, having a support system, building your own support, accepting support, help from family and friends, and regaining/restoring family relationships.

##### **Mental Health:**

Responses were related to being symptom free, manage mental health, being mentally healthy, gain stability, and avoid relapse.

##### **Responsible Use of Services:**

Responses included participating in services, keeping appointments, having access to, maintaining, consistency in services like support (peer, group), hospital, and case management.

##### **Employment:**

Responses were related to being employed, regain employment, be able to attain employment, and gain skills to attain employment.

##### **Stability:**

Responses included having stability in our life; achieve your goals, receiving help and support to reach stability.

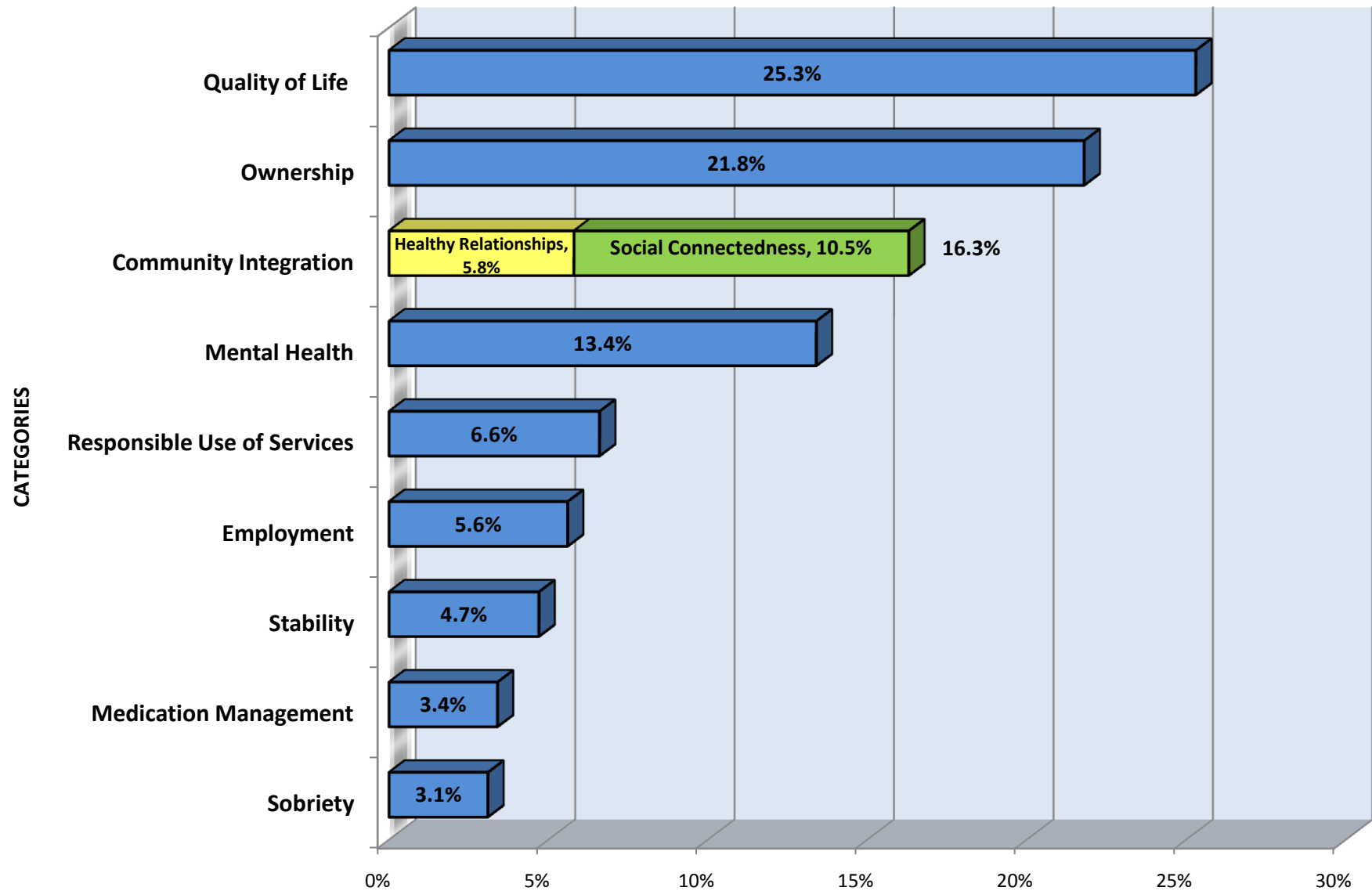
##### **Medication Management:**

Responses included taking medication properly, continue to take medication, and also not taking medication anymore.

##### **Sobriety:**

Responses referred to staying sober, clean, free from substances, overcoming addiction, living life without addiction, and prevent relapse.

#### Question 4: Describe what recovery means to you



SMI System Transformation Focus Groups 2010

## **Question 5: *Describe what helps you to improve your living situation.***

### **Personal Growth:**

Responses include client's individual growth: peace, one day at a time, daily improvements, not isolating, have your voice be heard, living independently, making progress, staying sober, being empowered, be positive, staying active, fulfilling goals, motivation, and good sleep.

### **Social Supports:**

Responses relate to having social supports: reaching out to neighbors, getting along with people, functioning in society, having friendships, good relationships, social time, socialization, being included, human interactions, date groups and friend/family supportive relationships,.

### **Living Arrangements:**

Responses are specific to having better housing and improving living situation: positive, peaceful, and clean living environment, safe, secure, stable and maintain housing, living comfortably, and have housing available.

### **Treatment:**

Responses include receiving mental health services: welfare checks, home visits, help from clinical team, proper medication, receiving and accessing to services, treatment plans, and counseling.

### **Community Based Resources:**

Responses relate to accessibility to resources and education: access to vocational resources/training, employment, art, music, reading, utilities, daily living skills, goal planning, education, food, clothing, and more availability of resources and education opportunities.

### **Safety:**

Responses are specific to living safely: feeling safe, having a safe place to go, safe housing/living situation, and safe social contacts.

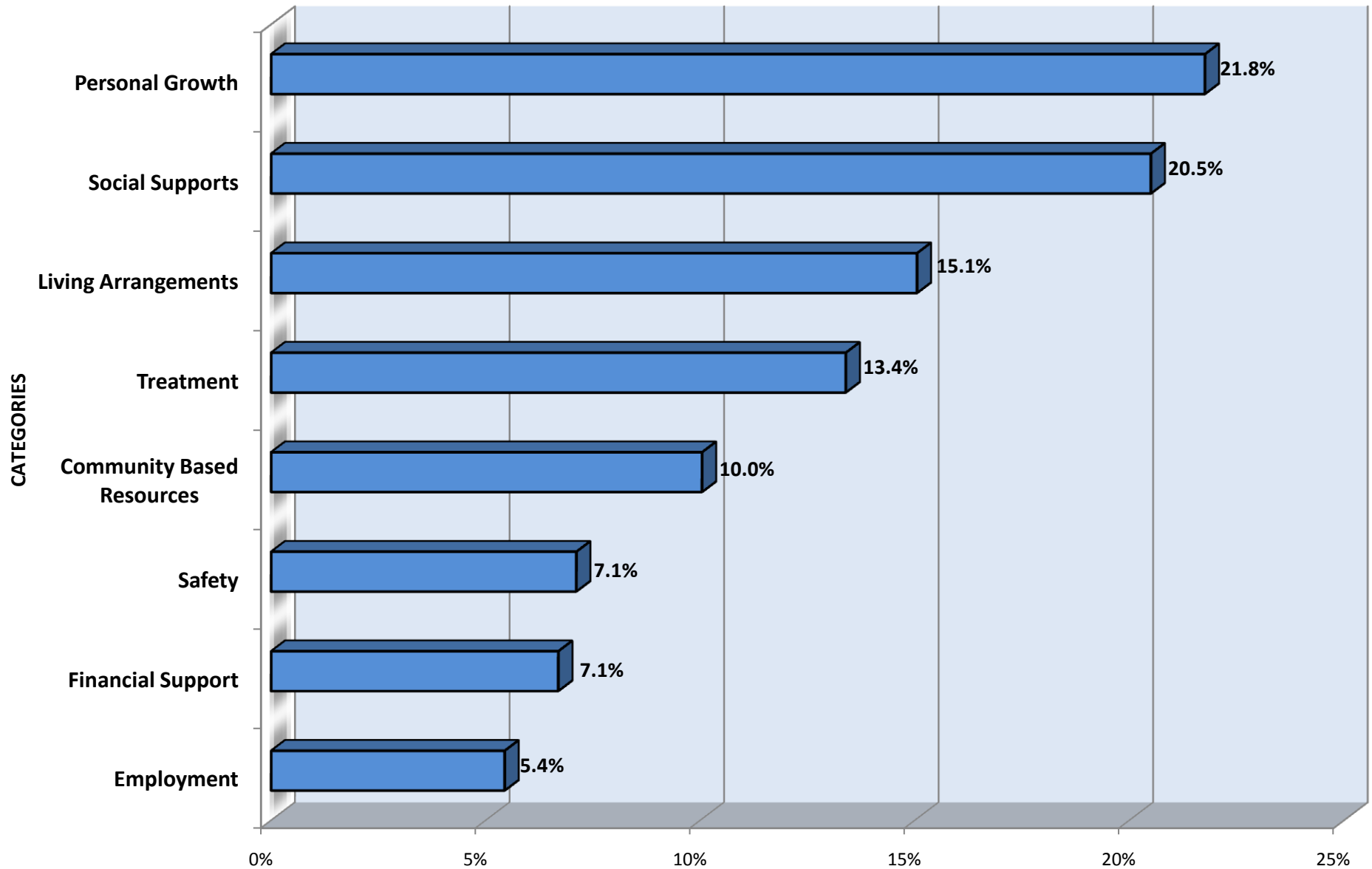
### **Financial Support:**

Responses include increasing financial support: more/having money, help with bills, budgeting, SSI increase income, less money on rent and more affordable place to live.

### **Employment:**

Responses relate to being employed: jobs, working, look forward to work, and being able to work.

### Question 5: Describe what helps you to improve your living situation



SMI System Transformation Focus Groups 2010

**Question 5a: Describe what “belonging to” or “being connected to” the community means to you.**

**Social Supports:**

**Relationships-**

Responses relate to developing relationships: social support, having other people around, social networking, knowing your neighbors, having meaningful relationships, building trust, personal social interactions, socialization, having healthy relationships, someone to call, and being around safe people. Family and Friends: a support system that include family and friends, having and making new friends, having contact with family outside of the home, family functions and regular contact with family and friends.

**Community Involvement-**

Responses are specific to being involved in the community: volunteering, social activity clubs, being productive, involved in social groups and programs, reaching out to community, being an active member of community, connections through hobbies/sports, access to STAR, NAMI involvement, and being engaged politically.

**Support Services/Resources:**

Responses include connections to support services/resources: support groups, transportation, schools, housing, financial assistance, utilities, and having basic needs met.

**Acceptance:**

Responses relate to community acceptance: accepted by non clinic groups, treated like any other member, sense of belonging, , not feeling like an outcast, feeling welcomed, inclusion by community, fitting in, accepted for who I am, and to not be treated “bad” because of background.

**Self Esteem:**

Responses include having self esteem: recognize self worth, feeling important, feeling valued, empowerment, having pride in community, and being respected as human being.

**Personal Engagement:**

Responses relate to having personal engagement: not isolating, staying out of apartment, not being alone, and having a life outside of the clinic.

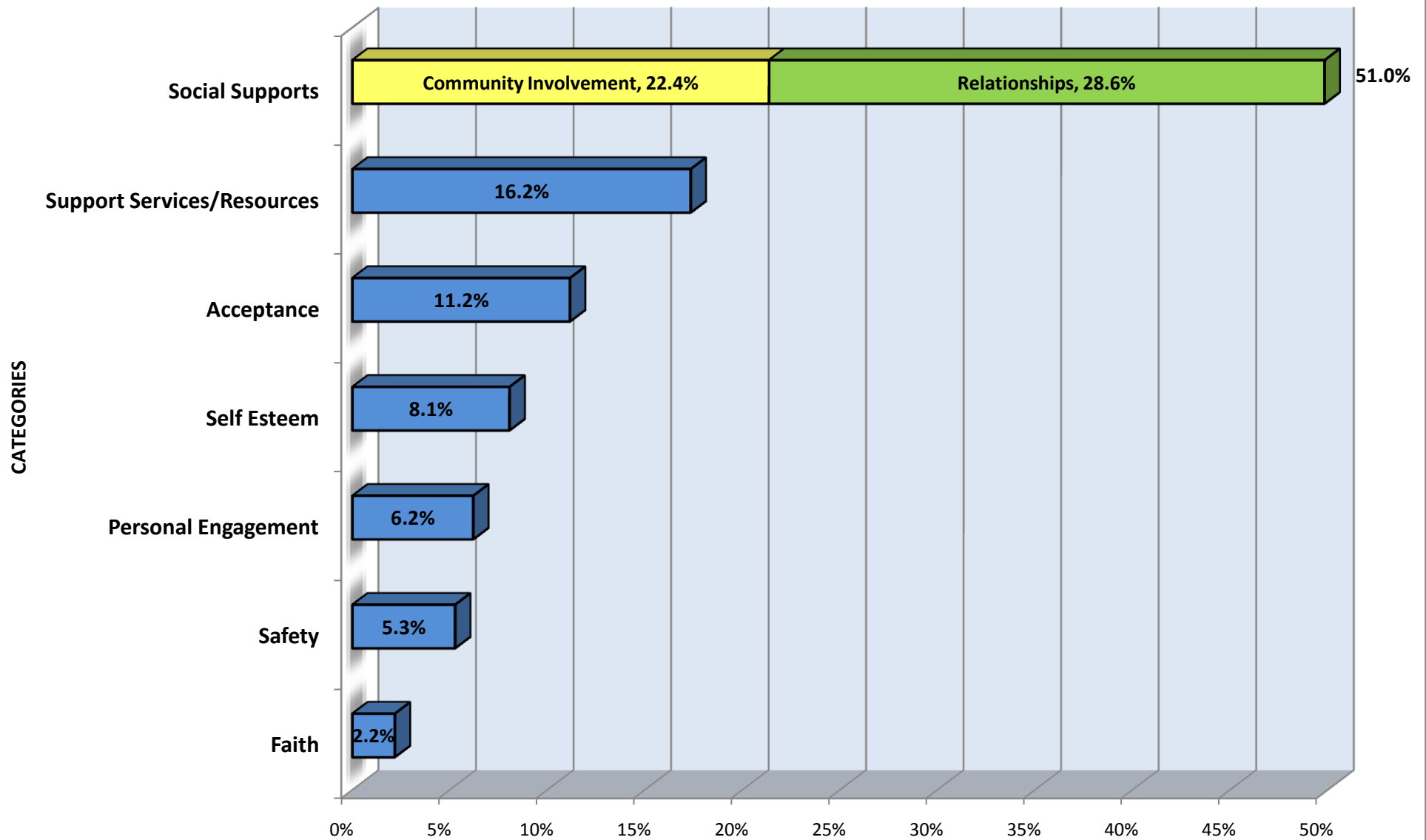
**Safety:**

Responses are specific to personal safety: feeling safe, a place that is your own, sharing when safe, being around safe people, and emotional and physical safety.

**Faith:**

Responses include being involved in church: church on Sunday, spiritual support groups and being around people with the same beliefs.

**Question 5a: Describe what "belonging to" or "being connected" the community means to you?**



## **Question 5b: *Describe how choice is important in directing your treatment.***

### **Informed Decision:**

Responses are specific to the ability of making informed decision in treatment: choice is the end all be all, learning of choices available, information to make good/right choices, give me options, knowledgeable, and being educated.

### **Involved in Treatment:**

Responses include being involved in treatment: more willing to participate in treatment, being included in treatment process, having a voice, playing a role in suggestions, providing positive input, it's your treatment, should have a say so, and self advocacy.

### **Ownership of Treatment:**

Responses relate to having ownership of your treatment: help take care of self needs, feel in control, I have value, self empowerment, you are in the driver's seat, direct own treatment/treatment plan, feel independent, and personal responsibility.

### **Rights:**

Responses are specific to client's rights: honoring rights, right to choose, freedom to choose, and right to privacy.

### **Medication Decisions:**

Responses include choice in medication: able to choose alternatives, rights to take/not take medication, able to discuss medication, and access to medication like generics.

### **Respect:**

Responses relate to feelings of respect: be respected, be understanding, be valued in process, building trust, being acknowledged, and increase in self worth.

### **Individualized Care:**

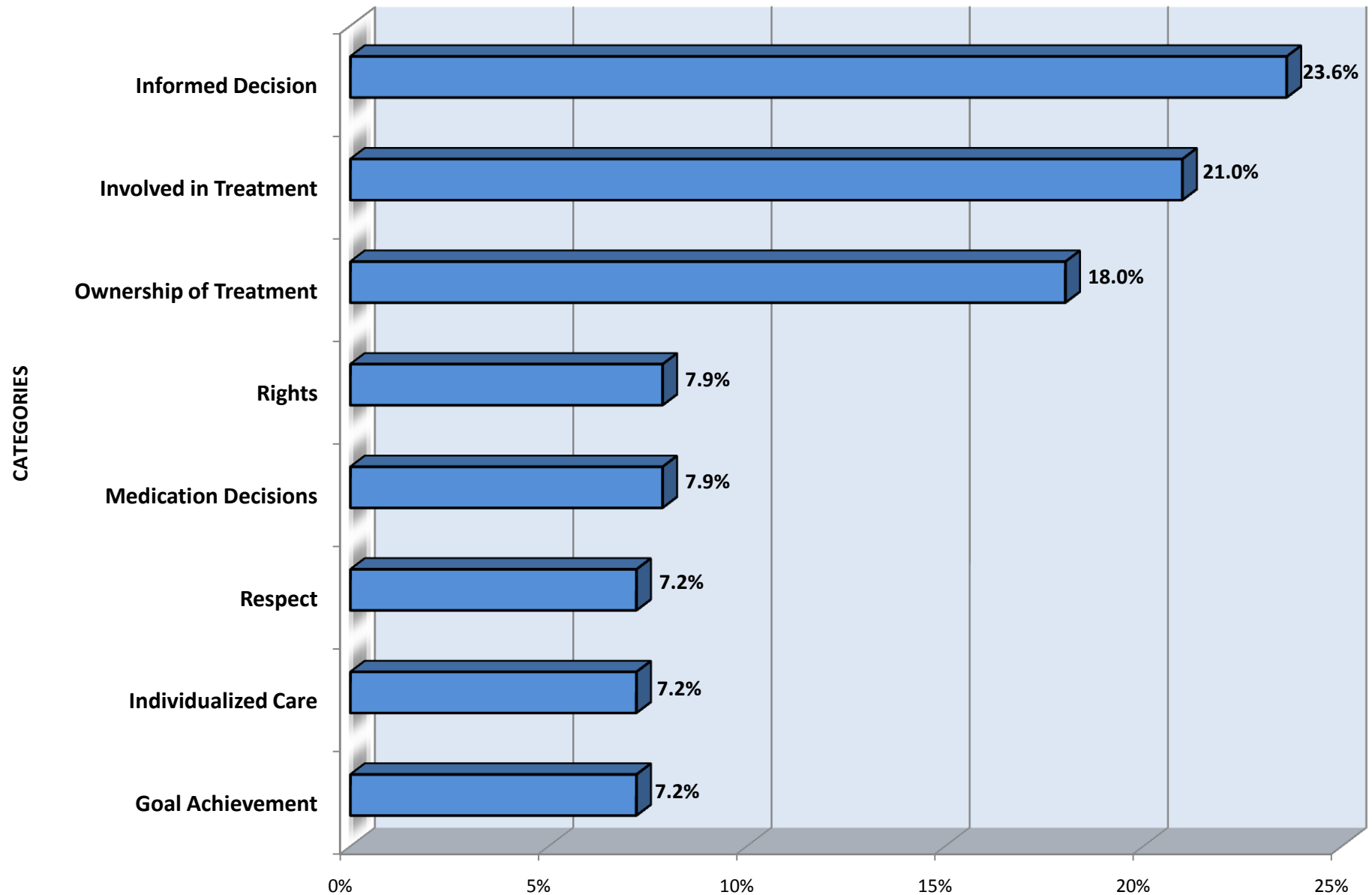
Responses are specific to individualized services: one-size does not fit all, not everyone is the same, have different needs, ability to get treatment that fits you, promote the individual, and decisions by the client.

### **Goal Achievement:**

Responses include assistance in achieving goals: filling your goals, help reach goals, help speed recovery, support recovery, and choice reflects in my goals.



### Question 5b: Describe how choice is important in directing your treatment



**Question 5c: *Describe a behavioral health system that promotes its members toward graduation.***

**Treatment:**

Responses relate to providing mental health services: case management, counseling, accurate treatment, having an ISP, treatment plans, housing treatment programs, outcome treatments, recovery programs, symptom management, peer to peer training and having quality care.

**Community Based Resources:**

Responses include availability of resources and education: help in gaining employment, education, life skills classes, skills training, Star West, ensure basic needs like shelter, food, safety, Spanish, nutrition classes, money management, and transitional homes.

**Social Supports:**

Responses are specific to giving clients support: peer support, mentors, compassionate, establish outside support, acceptance, guidance, feeling valued, understanding, encouragement, and respecting client and family.

**Success:**

Responses relate to client being successful: seeing progress, a system that celebrates achievements, live successfully, sense of accomplishment, motivation, and celebrate big or small.

**Graduation Terminology:**

Responses include clients concerns with the word “graduation”: journey is more than graduation, don’t like the word ‘graduation’, sounds like getting kicked out, don’t understand, define graduation, graduation to what, and use success instead of graduation.

**Independence:**

Responses are specific to becoming more independent, reduce dependence, have self sufficiency, and independent living.

**Goal Achievement:**

Responses relate to client’s goal achievement: successfully complete program, help reach out goals, set attainable goals, notice when goal is accomplished, and working towards goals.

**Individualized Care:**

Responses include having services more individualized: address individuals specific needs, treat as an individual, client directed treatment, and client integration.

**Community Involvement:**

Responses are specific to have client be involved in community: the village model, more community involvement, encourage member to be active member in community, socialization, help to function in society, assist in making connections with other people, giving back and contributing to society.

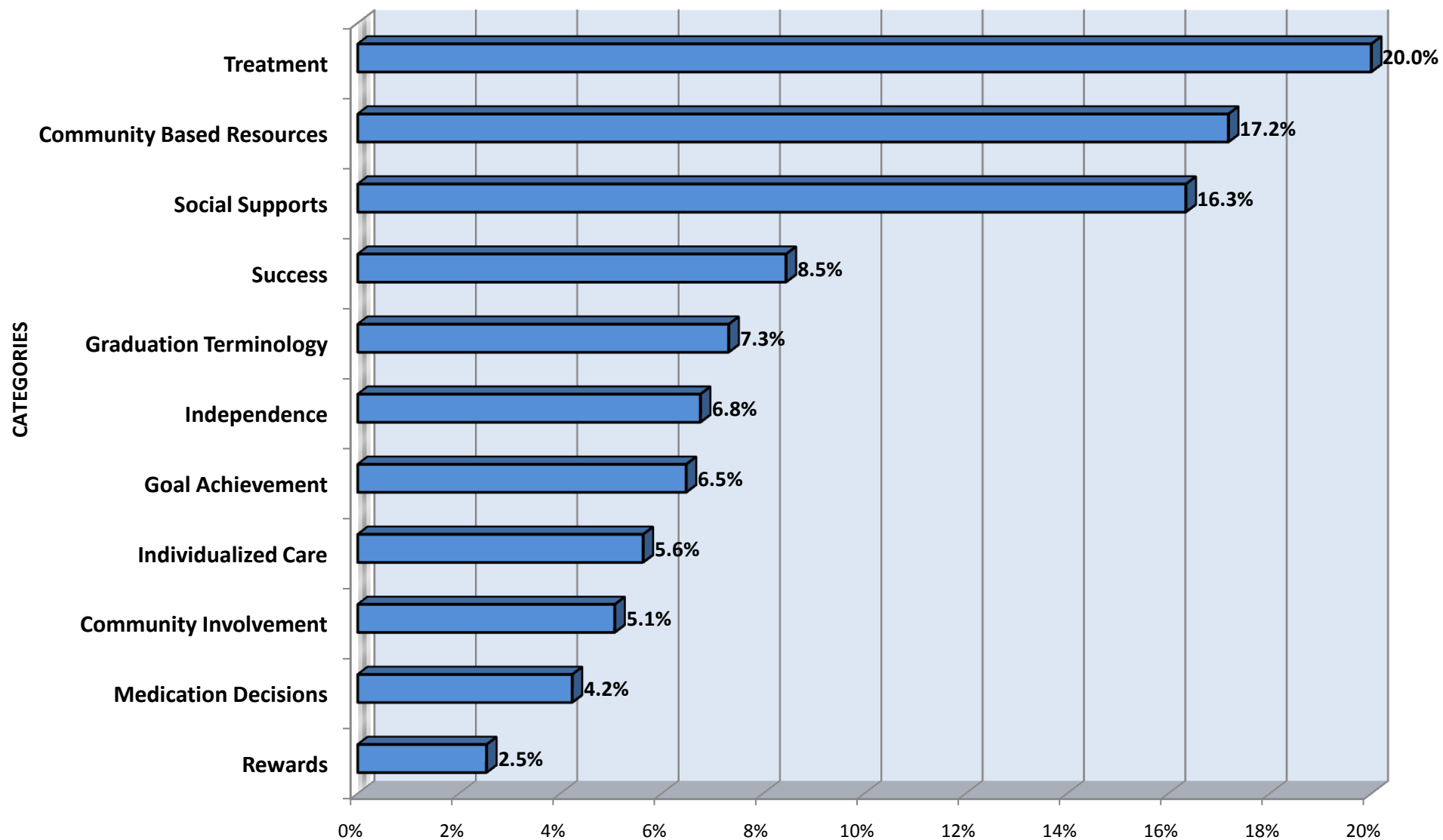
**Medication Decisions:**

Responses relate to medication management: take medication, getting medication, and unobtrusive access to medication.

**Rewards:**

Responses include giving rewards for graduation: use rewards, get certificates, get incentives, establish rewards system to encourage and motivate, and recognition from our team.

## Question 5c: Describe a behavioral health system that promotes its members toward graduation



## **Question 6: *What rights are most important to you within the behavioral health system?***

### **Access to Services:**

#### **Medication-**

Responses were specific to right to choice in medication, right to take and not take, receiving the proper, most effective medication and to have medication explained to you.

#### **Community Based Resources-**

Responses were specific to the right to receive and/or be referred to as necessary to resources like transportation, legal, housing/living, jobs/employment, and vocational training.

#### **Services-**

Responses centered on service delivery and the right to receive accurate, proper, prompt, consistent services like case management, treatment planning, support services and assessments and have services be available.

### **Respect:**

Responses included the client's right to be treated with respect, dignity, honesty, care and to be listened to and valued and being treated like a human being/person/individual, and having eye contact with client. Responses included right to fair treatment, equal opportunity in service choices, and not being judged.

### **Choice:**

Responses had to do with the right to choose treatment, services, providers, medication and also right to refuse medication/treatment.

### **Confidentiality:**

Responses were related to client's right to privacy, confidentiality and the enforcement of the consumer bill of rights and of HIPAA laws.

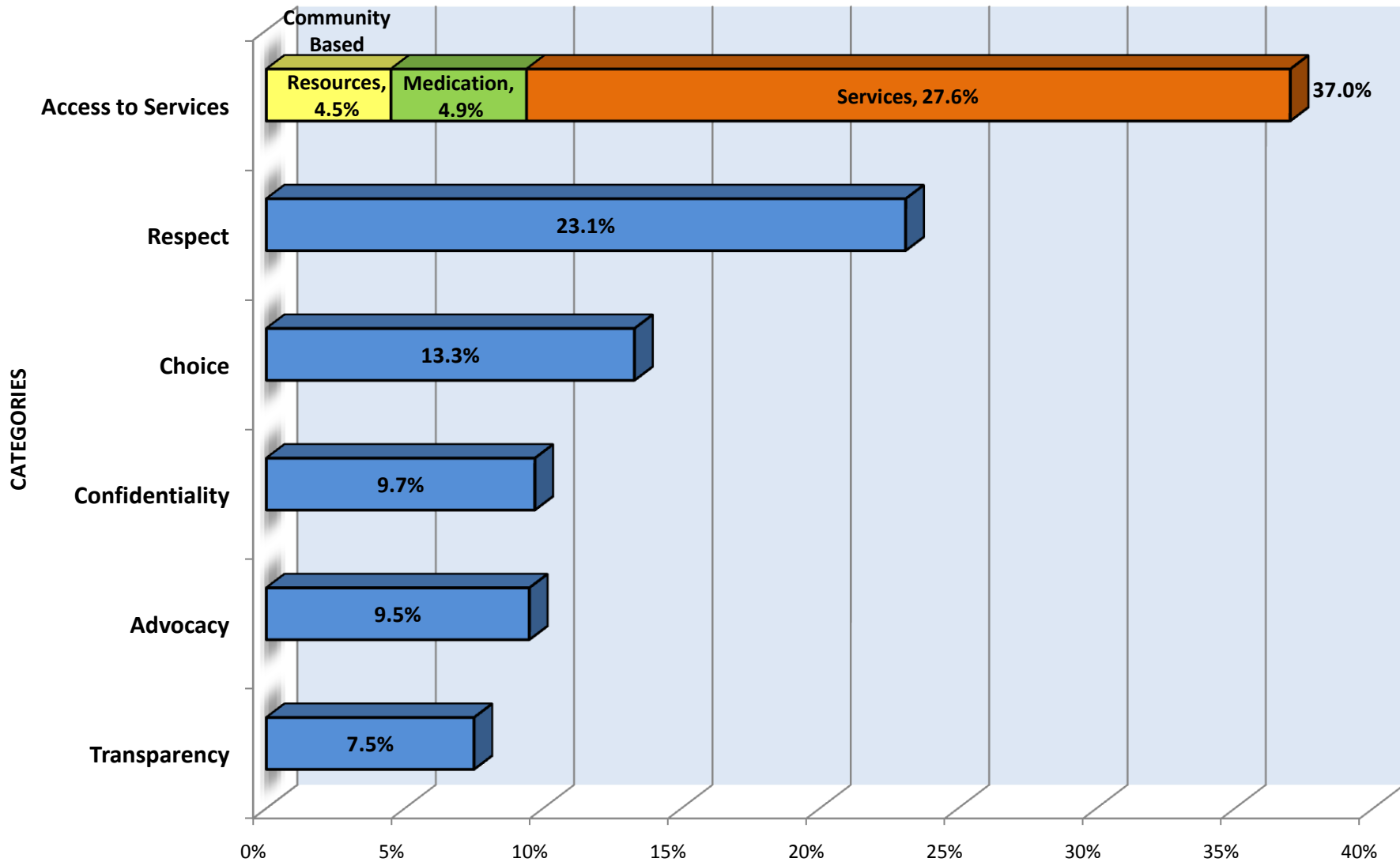
### **Advocacy:**

Responses included right to have a voice, freedom to speak, especially opinions, advocate for one's self, and be involved in your own treatment.

### **Transparency:**

Responses included the right to be informed and/or educated regarding client rights, consent, and about the grievance and appeal process.

## Question 6: What rights are most important to you within the behavioral health system?



**Question 7: Do you have any additional concerns or comments you would like to share about the way the behavioral health system works?**

**Services:**

**Services/Treatment-**

Responses are specific to various services and treatment: get proper services, improve continuity of care, want brand name medication, ISPs anti-productive, intake takes too long, increase service quality and efficiency, more family support services, and more support staff. Accessibility: better availability, greater doctor accessibility, and referral to counseling processes are too long.

**Community Based Resources-**

Responses include clients wanting more resources: more help with transportation, education, vocational assistance, legal aide, community resources, social security, housing, food, jobs and freedom to work.

**Care Management-**

Responses are specific to concerns regarding case management: case manager are overworked, should have limited caseload, overloaded caseloads, want consistent case manager, reduce turnover, and don't have enough attention because of high caseload.

**System:**

**Funding-**

Responses relate to clients concerns regarding funding: more SMI funding, funding for transportation, concerns with budget, our needs don't change with budget, and concern with budget cuts. Title 19 Concerns: concerns with cuts to Non-Title 19 clients, NT19 are 2<sup>nd</sup> class citizens now, better services for NT19, open groups to NT19-even for small fee, too many NT19's cut off, lack of help to NT19, NT19 should also be entitled to services. Eligibility: want help to stay on AHCCCS, freedom to work, fear of losing eligibility, and simplify eligibility.

**BH System-**

Responses are specific to various aspects of the behavioral health system: look at all layers of administration and process, system works too slow, want a system with stricter confidentiality, hate politics involved in my health, current system is often reactive-should be recovery focused, need DBHS prevention in place, more public forums, responsiveness to focus group, and reduce excessive oversight.

**Relationships:**

**Respect-**

Responses relate to the member and respect: respect individuality, learn empathy, treat client/family appropriately, lack of respect, need to treat more human, respect service dog, have dignity, understanding of family members, should listen more, and recognized whole person including culture and religion. The voice of the member: voice opinions freely, have input, be self advocate, and take control of own treatment and be heard.

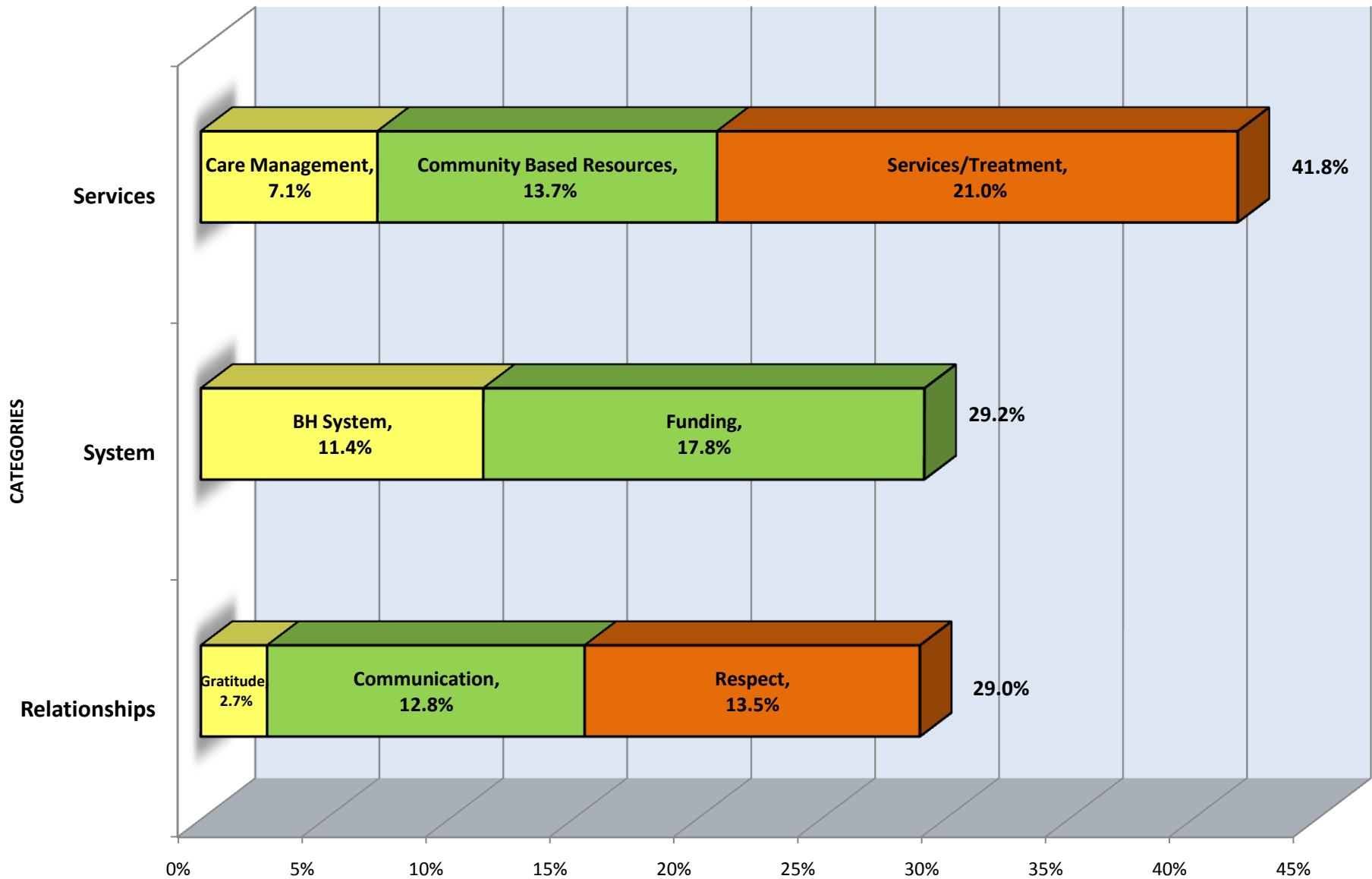
**Communication-**

Responses relate to communication: better responsiveness, better communication between team members, keep member informed of treatment, notification of changes in case management, better access to communication, effective communication, monthly publication of news, less/no voicemail, no answering machines during business hours, and improve internal communication to better know the client.

**Gratitude-**

Responses relate to client's positive feedback on services: thank you for all the help, a lot safer than 20 years ago, it is awesome and works if you work it, thanks to team and case manager, mental health services is doing a good job, see system as positive, and feel more respected

**Question 7: Do you have any additional concerns or comments you would like to share about the way the behavioral health system works?**







# Statewide Arizona American Indian Behavioral Health Forum II

“Policy & Service Delivery in a Changing Environment”

## **Final Report**

February 15-16, 2012  
Cliff Castle Conference Center  
Camp Verde, Arizona

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*\*Note: All power point presentations can be found at the ADHS Native American website at <http://www.azdhs.gov/diro/tribal/> and at the ADHS/DBHS website.*

## **Acknowledgements**

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### Financial:

Eagle Feather (\$5,000):

- Pascua Yaqui Tribe TRBHA
- Gila River Indian Community TRBHA
- Verde Valley Guidance Clinic
- Northern Arizona Regional Behavioral Health Authority (NARBHA)

Medicine Wheel (\$2,500):

- Community Partnership of Southern Arizona RBHA
- Magellan Health Services of Arizona RBHA
- Cenpatico Behavioral Health of Arizona RBHA

Healing (\$500):

- Parc Place – Acadia Health Care

### Host:

The Yavapai-Apache Nation

### Fiscal Agent:

Walk-in-Balance Center, Inc.

## **Executive Summary**

On February 15-16, 2012, the Statewide American Indian Behavioral Health Forum II: *Policy and Service Delivery in a Changing Environment* was convened. Multiple agency partners sponsored the Forum. The primary partners were the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), the Tribal and non-tribal Regional Behavioral Health Authorities (TRBHA/RBHA) and the Yavapai-Apache Nation. The Forum's overarching goal was to provide an opportunity for Arizona tribal representatives and behavioral health providers to present updates and share accomplishments and challenges, to discuss current state and federal policy issues impacting service delivery, and share concerns and barriers to enhancing the delivery of behavioral health services for American Indian communities. The Forum was designed to build upon Forum I recommendations and provide an opportunity for participants to describe how past issues had been addressed and convey any outstanding concerns.

The Forum included general session speakers and panel presentations. The event was attended by 111 individuals from across the state, including state, tribal, and federal representatives and consumers of behavioral health services. This Final Report includes summaries of presentations and discussions, as well as a synthesis of needs and priorities expressed by the attendees. Considerable progress has been achieved in strengthening the behavioral health delivery system, although several recommendations were made to address the strict requirements that TRBHAs are subject to, additional funding to support integration in rural areas, and continued consideration for the value and need for cultural competency. It is apparent that service and infrastructure gaps and barriers still exist. This underscores the need for further discussions and service improvements. The evaluation summary shows an overwhelming number of participants' expressed overall satisfaction with the Forum, presentations, and presenters' level of knowledge of the topics. They were pleased with the content and usefulness of the presentations. The venue and location garnered high praise.

## Introduction

On February 15 and 16, 2012, multiple agency partners including the Arizona Department of Health Services (ADHS), the Tribal and non-tribal Regional Behavioral Health Authorities, and the Yavapai-Apache Nation sponsored the statewide American Indian Behavioral Health Forum II. The theme for Forum II was *Policy and Service Delivery in a Changing Environment*. This report summarizes the proceedings and participant input received at this event.

## Purpose

The purpose of Forum II was to provide an opportunity for Arizona tribal representatives and behavioral health providers to provide updates and describe accomplishments and challenges to tribal, state, and federal leadership and participants in Forum II.

Forum II Objectives build upon Forum I, to:

- Provide an opportunity to offer input on outstanding concerns;
- Provide information on current state and federal policy issues affecting service delivery; and,
- Provide opportunity for T/RBHA, IHS, Tribal (638) and Urban Indian Health programs to address their concerns for enhancing service delivery in Arizona American Indian communities.

## Background

Tribal, state and federal behavioral health board members, administrators and clinical leaders from all Arizona Indian Tribes were invited to participate. One hundred eleven individuals attended with 43 representing 12 of Arizona's 23 Tribes. Chief Executive Officers and staff from Tribal and Regional Behavioral Health Authorities (T/RBHAs) were present. Eighteen representatives from the Urban Indian Health Programs (UIHP) and the Indian Health Service (IHS) also attended. See **Attachment 1** for a full list of Forum II attendees.

The event included general session speakers and panel presentations on various topics and behavioral health program updates. See **Attachment 2** for a copy of the Forum II agenda.

A statewide Planning Committee designed the agenda to fulfill the Forum II objectives, to build on Forum I recommendations and to provide an opportunity for participants to describe how the issues had been addressed in their areas, as well as any outstanding concerns. See **Attachment 3** for a listing of the Planning Committee members.

## Evaluation Summary

Overall, the Forum was given a 96% satisfactory rating. An overwhelming number of participants expressed overall satisfaction with the Forum, presentations, and presenters' level of knowledge of the topics. They were pleased with the content and usefulness of the presentations. The venue and location garnered high praise.

According to the feedback, respondents enjoyed the length and format of the Forum. They would like to hear more from tribal leaders, and suggested topics for future forums, such as RBHA and Tribal success stories, cultural sensitivity, rural/tribal service issues, AHCCCS reimbursement and billing specifics, etc.

Areas of follow up activities that respondents suggested include getting shared updates on urban and tribal programs, listing of contact information for attendees, and receiving status updates on ADHS and AHCCCS for the upcoming fiscal years. See **Attachment 4** and **5** for a detailed evaluation report and list of abbreviations.

## Proceedings – Day One

**Welcome and Opening Remarks:** Michael Allison, Native American Liaison, Arizona Department of Health Services (ADHS) and Fred Hubbard, Executive Director of the Advisory Council on Indian Health Care, both welcomed the attendees. Don Decker, Apache Spiritual Leader, gave the opening prayer. The Yavapai Apache Nation Honor Guards, Larry Jackson and Billy Garner, posted the colors. Opening remarks were offered by Linda Evan, Councilwoman of the Yavapai Apache Nation. The Honorable Chairman, David Kwait, Yavapai-Apache Nation, also joined the Forum and addressed the Forum attendees.

**Forum I Report and Forum II Objectives:** Following the opening welcome and remarks, a report of the Forum I proceedings was provided by Lydia Hubbard-Pourier, ADHS/DBHS Tribal Contract Administrator, followed by a description of the intended objectives of Forum II by Alida Montiel, Health Systems Analyst, ITCA.

All power point presentations can be found at the ADHS Native American website at <http://www.azdhs.gov/diro/tribal/> and at the ADHS/DBHS website.

**Budget and Economic Overview:** Tom Betlach, Director, AHCCCS, presented an update on the state's economy and the budget for the state, including AHCCCS. Mr. Betlach described the Arizona economic trends, recent Federal policy and budget decisions, including the impact on the AHCCCS budget. He showed the growth in the AHCCCS population, as well as the trends in enrollment and AHCCCS spending. He also described the status of Tribal issues recently

changed or still pending at AHCCCS. Mr. Betlach reported that numerous tribal consultation sessions have been held over the past two years, due to the many policy and budgetary changes. He noted the accomplishment of the federal waiver status and shared that payment levels continue to increase for IHS and 638 tribal facilities. He stated the future challenges facing AHCCCS and consequently delivery of behavioral health services and health care to tribes and tribal members are: (a) Implementation of Health Care Reform – Impact of 350,000+ additional enrollees; (b) Development of the Health Insurance Exchange – Arizona received a \$29 million establishment grant and RFP development for Exchange functions; (c) Development of Health-e-Arizona as part of infrastructure development; (d) Developing a contract for health integration efforts; (e) Establishment of Maricopa County Seriously Mentally Ill (SMI) integrated health home for SMI members; and, (f) Children’s Rehabilitative Services moving to develop a single health care plan for all eligible kids.

Participant Comments/Questions: *How will the elimination of the one-cent sales tax affect Medicaid services in FY2014?* Mr. Betlach replied that the expiration of the one-cent sales tax would create a loss of approximately one billion dollars; however, voters must approve to eliminate the one-cent sales tax initiative.

Participant Comments/Questions: *There is a lack of available services and there are challenges with bringing staff to rural areas. Non-Title XIX client needs are not being addressed or met. For example, young men without children are no longer eligible for behavioral health services. They are often in high-risk categories for needed services.* Mr. Betlach commented that the decrease in covered services to only medication management of childless SMI adults was necessitated by state budget cuts. Mr. Betlach indicated that this coverage for childless adults previously cut in the state budget is being reviewed for return of some of the coverage benefits and the reinstatement of those particular benefits might be based on outcomes of pending lawsuits.

Participant Comments/Questions: *What is the status of exemptions for American Indians?* Mr. Betlach indicated that CMS is still reviewing this. AHCCCS hopes to receive a response from CMS soon.

Participant Comments/Questions: *Verde Valley Guidance Center (VVGCC) has hired primary care providers in the NARBHA region and has experienced good outcomes. VVGCC has found there is no integrated health IT system in existence. Is AHCCCS aware that communication systems do not “speak” to each other, as there is no “one” medical record for integrated health services?* Mr. Betlach agreed that there is a need for IT/data to flow between agencies and that the integrated health model is forcing systems to recognize that it is time to change the way AHCCCS does Medicaid/Medicare business. AHCCCS is facing these challenges head on.

Participant Comments/Questions: *Due to current issues with auto-enrollment, there have been recent recommendations to include a choice box on the AHCCCS eligibility form for American Indians (AIs) to choose their RBHA/TRBHA. Will this be implemented?*

Mr. Betlach indicated that he would be following up on this when planning for the changes to be implemented in FY 2013.

**Regional Behavioral Health Authorities (RBHA) - Tribal Liaison Panel:** This panel presentation finished the morning session of the first day. Each of the four RBHAs, Northern Arizona Regional Behavioral Health Authority (NARBHA), Community Partnership of Southern Arizona (CPSA), Cenpatico, and Magellan provided an overview of the Tribal Liaison's role in the RBHA system, including a description of the structure, unique aspects, accomplishments and efforts to enhance behavioral health services to tribal members on-and-off reservations in their ADHS contracted geographic service areas (GSAs).

NARBHA – Northern Arizona Regional Behavioral Health Authority – Cheri Wells, Tribal Liaison opened up the panel presentations by commenting that NARBHA serves eleven tribes in their GSA. She highlighted NARBHA collaboration efforts with Tribes, including honoring sovereignty by formalizing agreements, developing crisis protocols with local stakeholders, advancing communication through telemedicine and Protocol crisis line, providing trainings to advance skills of providers, and facilitating ongoing monthly and quarterly tribal coordination of care meetings. Ms. Wells indicated that Memoranda of Understanding (MOUs) are in place for NARBHA providers, including Mohave Mental Health Clinic (MMHC) with Hualapai and Ft. Mojave Indian Tribes and Southwest Behavioral Health Services (SBHS) with Hualapai and Ft. Mojave Indian Tribes, and The Guidance Center (TGC) with the Havasupai Tribe. She noted 33 crisis calls and 23 non-crisis calls were received from Havasupai, Hualapai, and Hopi (July to December 2011). Ms. Wells concluded by sharing that various trainings are offered, such as Applied Suicide Intervention Skills Training (ASIST), Tribal Involuntary Commitment Process, and Mental Health First Aid.

Magellan Health Services of Arizona – Darcy Roybal, Tribal Liaison, presented an overview and stated that Magellan serves three tribes and partners with two TRBHA's in their GSA (Maricopa County). She notes their efforts to improve coordination, quality, access to care, and trust relationships with tribes through enhanced tribal coordination and community involvement. She further highlighted their successful collaborations: Crisis Services in two tribal communities with formal agreements with tribes; IHS and Urban Indian health providers, advanced Adult and Children services in the San Lucy Village of the Tohono O'odham Nation; Transition Age Youth Forum; Southwestern Institute for the Education of Native Americans (SIENA), Native Youth Suicide Prevention initiative; and Tribal Raise Your Voice. She also mentioned a co-located



collaborative agreement with IHS Phoenix Indian Medical Center (PIMC) to place Magellan providers at their facility. She emphasized that the agreement strengthens service delivery in the areas of crisis preparation and recovery, mental health evaluations, and connectivity with high-risk patients with primary care.

Cenpatico Behavioral Health of Arizona – Sheina Yellowhair, Tribal Liaison, commented that Cenpatico serves seven tribes in their three GSAs and eight counties. She highlighted their ongoing initiatives, including letters of agreement, tribal collaboration, improving access to services, community outreach, and cultural competency. Tribal collaboration efforts include monthly and quarterly collaboration meetings and representation on a Tribal Task Force. She further noted successful collaborations in developing crisis services protocols. Ms. Yellowhair concluded by highlighting the expansion of the MMWIA initiative - “Meet Me Where I Am for Tribal Communities.” The initiative focuses on keeping the family unit together and providing the services that will most benefit the child including access to support services. This local tribal model incorporates tribal input to enhance a culturally specific service for each tribe.

Community Partnership of Southern Arizona (CPSA) – Julia Chavez, Tribal Liaison, commented that CPSA serves the Tohono O’odham Nation and partners with the Pascua Yaqui TRBHA located in their GSA, Pima County. She shared their accomplishments: established MOU, expansion of adult and children services, and enhanced crisis services are successful collaborative efforts with the Tohono O’odham Nation. She noted they were the first outpatient facility located on tribal lands. Ms. Chavez also described other community involvement efforts, including meetings and participation on Prevention Coalition/Suicide Prevention Task Force, and the Red Road to Wellbriety/Not Simply Red Committee.

Common threads running through the presentations were: recognition of tribal sovereignty through the development of formal agreements with tribes to provide services on tribal lands, enhanced crisis services for tribal members, and technical assistance to tribal behavioral health programs. Staffing inconsistencies were noted as one GSA (NARBHA) geographically covers approximately 50% of the state, serving 11 of the 22 tribes in Arizona, and 50% of the state’s American Indian population. Another Tribal Liaison works with tribes in three of the state’s six GSAs. It was noted that all the Tribal Liaisons travel great distances to carry out the RBHA responsibilities in coordination with Arizona tribes.

Participant Comments/Questions: *A participant commented on the numerous positive developments, which have been accomplished since Forum I, two years ago, when the RBHA Tribal Liaisons were hired.*

**Tribal Regional Behavioral Health Authorities (TRBHA) Panel:** This panel presentation opened the afternoon session of the first day with the Gila River, Pascua Yaqui, and White Mountain TRBHAs and the Navajo Nation case management IGA all presenting. The panelists provided overviews of their unique TRBHA structure, descriptions of service populations, accomplishments, and challenges or barriers to enhancing services to tribal members.

Navajo Nation Department of Behavioral Health Services - NRBHA – Genevieve NezHolona, Clinical Director, began the panel presentation by describing the unique offering of comprehensive case management services on the Navajo Nation. She specified revenue is generated from treatment and case management services. She highlighted staffing coverage, the utilization and volume of services provided, sizeable geographic areas covered, and demographics of the population served. The ADHS/DBHS-Navajo Intergovernmental Agreement (IGA) allows for the provision of case management services with additional funding from ADHS/DBHS for SMI housing and crisis services. Navajo RBHA will be moving toward full electronic case management, independent behavioral health professional for oversight of the paraprofessional case management services at each agency, and billing system modifications for case management services as a Tribal 638 provider.

White Mountain Apache Behavioral Health Services, Inc. (WMABHS) – Dr. Bill Arnett, CEO of the WMABHS, presented the tribal demographics, organizational history, and structure. Dr. Arnett shared the benefits of becoming a TRBHA and challenges in being a TRBHA. Two benefits highlighted were the prestige that being a TRBHA brought to the White Mountain Apache Tribe (WMAT) and the increased knowledge of services and of “what is possible” as a behavioral health program. Two challenges identified by Dr. Arnett are on changes in how the WMAT behavioral health program conducts business; transition from tribal management to a corporate board oversight and the necessity and requirement to develop and implement quality management. A main challenge indicated by Dr. Arnett is the ADHS/DBHS reporting requirements are burdensome and excessive. He further stressed that TRBHAs are not mini-RBHAs and that the reporting requirements are applicable to the RBHAs not the smaller TRBHAs with fewer resources. For the future, Dr. Arnett added that future business opportunities would be explored such as direct contracting with on-and-off reservation programs to increase quality and quantity of programming.

Gila River Behavioral Health Services (GRBHS) – Steven Green, Executive Director, and Priscilla Foote, Director, Gila River Behavioral Health Services (GRBHS), provided an overview of the organization’s transformation since 2005. They described the system integration of the four separately administered tribal and corporate behavioral health and substance abuse operations under the leadership of the TRBHA. The additional changes brought on by tribal council action

in 2011 joined the tribal substance abuse component and the Residential Treatment Center, under the TRBHA oversight, making the TRBHA the largest department of the Gila River Health Care Corporation. Gila River TRBHA has grown in size, employees, enrollees and types of services, including community-based services. System integration benefits included increased coordination of care, efficacy of care, uniform standards of care, improved access - “no wrong door” into the behavioral health system, and improved understanding of program services availability which resulted in better referrals and outcomes. Various issues related to continuity and service fragmentation were identified. Challenges identified by the Gila River TRBHA include excessive Quality Management (QM) requirements and reports to ADHS/DBHS. GRBHS suggested that ADHS/DBHS consider waiving some of the requirements that are not applicable for a smaller TRBHA as they are with the larger RBHA system.

Gila River TRBHA offered the following thoughts: (a) System integration and quality management are on-going processes, (b) Coordination and communication across the system is critical, (c) Common clinical documentation methods improve client care across the GRHCC system, (d) Opportunities for additional service expansion include the addition of “the Caring Housing”, the Gila River Indian Community (GRIC) nursing home, and (e) GRBHS is involved in more community initiatives and collaboration than ever before.

Pascua Yaqui Tribe - Sea Takah Na’ asuku (*Centered Spirit Program*) TRBHA – Dr. Clare Cory, Clinical Director of the Guadalupe Clinic, presented a description of services at Tucson and Guadalupe (Tempe). She stated that there are eight Yaqui communities in Arizona. She further highlighted the successful SAMHSA/SAPT funded prevention program at Guadalupe and the Lutu’uria Youth Group. Pascua Yaqui operates two off reservation services, a level II group home for boys and the Guadalupe Outpatient Clinic, both of which are the only tribal facilities that are state licensed. A unique aspect of the TRBHA is its CARF accreditation attained in 1999. A number of advantages to being a TRBHA were cited, consisting of the focus on enhanced network services, increased clinical coordination and services, access to grant funding, clinical training and collaborative efforts to improve services. Dr. Cory drew some attention to challenges such as the auto enrollment issue being a significant burden due to the large number of tribal members living off-reservation, and the administrative oversight by ADHS/DBHS and mandated requirements placing burdens on a small TRBHA with very limited resources. Future endeavors consist of negotiations with ADHS/DBHS to accept CARF accreditation in lieu of the annual Administrative Reviews. Additionally, Pascua Yaqui will work to advocate for traditional medicine as a reimbursable covered service. Pascua Yaqui will also participate in the TRBHA/RBHA/ADHS/DBHS workgroup to determine allocation criteria for the CMHS and SAPT block grants to ensure there is more equitable funding from the block grants for the TRBHAs and tribes.

Participant Comments/Questions: *Are referrals accepted by Gila River from other tribes?*

Steven Green responded yes, outside tribal referrals are accepted with consideration of GRIC tribal members having first priority.

**Tribal/638/Urban Program Panel:** The panel presenters of this mid-afternoon panel described the operations of non-TRBHA tribal and urban behavioral health programs. In addition, the presenters described their service populations, accomplishments and challenges affecting their programs.

San Carlos Tribal Wellness Center – Dr. Thea Wilshire, Clinical Director of the Wellness Center began the panel presentations by providing an overview history of the organization, the establishment of a P.L. 93-638 contract, integration into the Wellness Center, achievement of CARF accreditation and state and national performance awards. Dr. Wilshire described the challenges of the integration and bringing together three separate related programs to shape the Wellness Center. She further highlighted the benefits reaped of greater effectiveness and cultural competence, as well as the growth of additional services through the years. She added how accreditation, staff development and a team approach have contributed to the Wellness Center’s development into a well-established program. The Wellness Center, with offices in several locations throughout the reservation, provides a wide array of services, programs, activities, and resources to tribal members. Dr. Wilshire highlighted the telepsychiatry clinic initiated in 2009. Dr. Wilshire summed up by sharing their future goals: (a) greater use of performance indicators; (b) increased children services; (c) specialized services for Veterans; (d) Deaf Support Groups; (e) Post-Graduate training for Native American clinicians; (f) statistical tracking of program treatment data; and (g) Reservation-based specialized group homes.

Hualapai Health-Education and Wellness – David Brehmeyer, Special Projects Program Manager, Hualapai Health Education and Wellness Program, presented on the history of the tribal program and its current offering of services along with their new health building. Mr. Brehmeyer further discussed barriers including funding, geographic remoteness, and lack of access to qualified professionals. He thanked agency staff at NARBHA, AHCCCS, and ADHS/DBHS for their guidance and technical assistance provided to Hualapai.

He went on to share how billing and generated revenue have allowed Hualapai to expand services and hire additional staff. He concluded with sharing future plans to expand behavioral health services to their tribal detention center and Head Start program. Additionally, Hualapai intends to institute a new patient management system, and possibly acquire CARF accreditation.

Native Americans for Community Action (NACA) – Rob Robin, PhD, NACA Executive Director, described the early origin of the urban Indian Center in Flagstaff. Dr. Robin noted that NACA is a near full-service organization offering a comprehensive set of services and programs comprised of economic development, health promotion and prevention, substance abuse prevention, wellness center, family health center, workforce development and emergency social services. He stated there have been over 4,000 visits by clients of which 600 are substance abuse clients and 100 are mental health clients. Dr. Robin declared that while NACA Behavioral Health Program will continue work on improving program capacities, their main challenges are establishing a billing system for revenue generation and raising staff professional competencies and capabilities. A NACA Counselor gave a verbal presentation on the value of and need for cultural competency in working with tribal clients using tribal languages and clan relationships.

Participant Comments/Questions: There were no comments and/or questions for the panelists.

**Indian Health Service (IHS) Presentation** – The IHS Implementation of the Indian Health Care Improvement Act, Title I and VII – Behavioral Health Services and Related Provisions – The closing presentation of the first day was provided by Dr. Patricia Nye of the Tucson Area IHS, representing George Bearpaw, Acting Area Director of the Tucson Area. She presented a two page document. The first page depicts all of the twenty sections of Title I and VII, the status of implementation, and whether or not additional appropriations are needed to implement the program indicated in each section. The second page covered the references, and where to locate the IHS implementation updates on the IHS website. The handout provided a wealth of information and references.

Participant Comments/Questions: There were no comments and/or questions.

**Open Dialogue Session:** An “Open Microphone” session was held at the end of the first day to allow participants to ask questions and make comments on the first day proceedings. Fred Hubbard, Executive Director, Advisory Council on Indian Health Care, moderated this session.

Participant Comments/Questions on Funding Reimbursements for Behavioral Health Services Provided to Clients in Detention Centers: *Funding/reimbursement for behavioral health services for tribal detention center detainees is not available. How can we make this happen? San Carlos Apache Tribal Wellness Center stated it delivered approximately \$600,000 unreimbursed services at their tribal detention center.* Participants agreed that this is a problem throughout Arizona. Someone asserted that under the Utah correction system any Native American medicine man can go into the detention center as a clergy and get funding as a faith-based organization. An Inter-

Tribal Council of Arizona (ITCA) representative commented that this question was posed to the National Indian Health Board (NIHB). NIHB responded that services could be delivered up to adjudication. The ADHS/DBHS representative indicated that this prohibition of reimbursement is a CMS regulation. Each state can determine when eligibility stops. In Arizona, eligibility/funding stops once a detention center is entered. Some history about the issue was also imparted. The CMS regulation is based on the assignment of responsibility to the state prison systems and the responsibility of each state for care provided to state prisoners. Each state funds their prison systems to include health and behavioral health services. Tribal jails/detention centers are separate from the federal and state prison systems. Tribal jails were originally set up and funded through the Bureau of Indian Affairs (BIA). Health services including behavioral health services in the BIA operated jails were to be provided by the IHS facilities in tribal communities through Interagency Agreements. However, IHS is 60% underfunded to meet the health needs of Indian communities and most IHS facilities do not have sufficient behavioral health resources to provide services needed by tribal detainees. Tribes need to work with CMS to waive this requirement for tribes and 638 behavioral health programs and services to tribal jail and detention center detainees. An additional comment was made that there needs to be flexibility in the provision of services for youth in detention centers as they drop off AHCCCS when they are incarcerated. Additionally, there is a need for tribes to coordinate care prior to adjudication.

Participants Respond to the Question of What was Learned Today: An ITCA representative indicated that in the past there was a provision in RBHA contracts that excluded the reservation from the RBHA service areas. She stated she was glad to see that this had changed and that the RBHA Tribal Liaison positions had been established. Further, she indicated that there had been concern that these RBHA positions would be cut but was glad to see they remained as required Key Personnel in the RBHA contracts.

An IHS Psychiatrist expressed that he was impressed with the programming reported from the tribal behavioral health programs and the TRBHAs. He felt that people were thinking outside the box. He indicated that all areas needed to be involved in discussion regarding early childhood programs including support for expectant mothers. Further, he stated that there is a dilemma due to the inability to bill for pre-clinical services. He indicated discussion needs to occur on how to accomplish this needed change. He commented that there is obvious commitment to improving behavioral health service delivery to tribes as demonstrated by the number of participants at this forum.

A RBHA Tribal Liaison stated the TRBHA leadership impressed her. She appreciated TRBHA leadership being vocal about challenges. She explained that RBHA challenges are very different and declared that sovereignty status of tribes is apparent but not always taken into consideration in building working relationships with the tribes. She also stated that it is obvious that the 638 program at San Carlos Apache Tribe is flourishing.

A tribal participant indicated that a segment of the population with needs is not being addressed at this forum and that is the non-AHCCCS eligible adults. There are many men with emotional problems but are non-TXIX eligible.

A Hopi Guidance Center staff member commented that there is still a lack of services on reservations and challenges are high. The participant stressed the behavioral health needs on reservations are high and stated it is helpful to hear what other agencies are doing but some needs are still not being addressed. The participant highlighted CPS custody cases where children are removed from the home and then the parents are classified as “childless adults” and no longer qualify for AHCCCS benefits.

**Closing:** A summary of Day One was given by Fred Hubbard. The presentations and sessions for the first day of the Forum were completed and the Forum recessed.

**Reception:** An evening reception was held as a networking event and also as an opportunity to recognize the financial sponsors of the forum. Fred Hubbard was the EMCEE. The recognition was followed with a cultural presentation made by James Uqualla, Havasupai Medicine Elder and a performance by the Yavapai-Apache Nation Bird Singers.

### **Proceedings – Day Two**

Following welcoming and introductory remarks by Michael Allison, Native American Liaison, ADHS, the second day began with an ADHS status update.

**Status of State Behavioral Health Program & Health Integration:** Dr. Laura Nelson, Deputy Director, Division of Behavioral Health Services, ADHS, presented updates on Substance Abuse and Mental Health Services Administration (SAMHSA) initiatives, a budget overview and the Essential Health Benefits as a part of the Affordable Care Act. She further shared Arizona Governor Brewer’s Non-TXIX SMI proposed budget and anticipated benefits in controlling costs and improving healthcare outcomes through the integration of behavioral health and physical health services. Dr. Nelson summed up the outcome of community input sessions.

**Participant Comments/Questions:** *A comment was made by an ITCA representative that dialogue needs to occur regarding tribal choices for care. A question followed the*

*comment. Are the Health Resources and Services Administration (HRSA) 330 clinics going to be considered a part of the network in the Maricopa County pilot?* Dr. Nelson responded, yes.

Participant Comments/Questions: *What about services to the elderly with ALTCS?* Dr. Nelson replied that ALTCS receives funding and contracts with providers for those services. Provider contracts need to be reviewed and expectations need to be built into the contracts for improvements in coordination of care. She indicated that Electronic Health Record (EHR) is a part of the solution. In response to the comment that there are challenges of an EHR, Dr. Nelson replied there is currently no health record or system that talks to its counterpart.

Participant Comments/Questions: In regards to the comment concerning the need for increased funding to implement integration health care solutions for rural parts of Arizona and the need for additional funding to increase rural health services, Dr. Nelson indicated the need for more funding to develop the collaborative efforts as well as provide training. She also indicated that Telemedicine and the EHR should be considered as targets for consideration.

Participant Comments/Questions: *Where will the health information be housed? – Who will own it – the RBHA?* Dr. Nelson replied that as the RBHA contracts are transient, health information exchange issues are being reviewed. She indicated there is not an answer at this time.

**Integrated Health Panel:** This panel provided information on how their organizations integrate physical health care with behavioral health, discussed the implications of expanding health care integration program requirements, and evaluating unique issues that arise.

Phoenix Indian Medical Center - IHS – Dr. John Molina, Chief Executive Officer, began the panel presentations by describing the Phoenix Indian Medical Center and its service population. He drew attention to the three IHS agency-wide initiatives, which provide a strategic framework for reducing the unacceptable health disparities and improving the health status of American Indians and Alaska Natives. The three related initiatives of health promotion and disease prevention, chronic care and behavioral health were underscored. The behavioral health initiative will work to integrate primary care and behavioral health care in the IHS facilities through development of individual care teams working together in clinic settings. Dr. Molina stressed that IHS has a lot of work to do to integrate care and indicated that internally they have often “worked in silos”.

Native Health, Inc. – Walter Murillo, CEO, said that Native Health is a Federally Qualified Community Health Center (FQHC) or Community Health Center (CHC). Native Health is



structured and designed to eliminate system-wide barriers to accessing health care and offer comprehensive primary and preventive medical, dental, and mental health/substance abuse services to predominantly uninsured and medically underserved populations. Native Health primarily focuses on offering services to the American Indians residing in the Phoenix urban area. Native Health and its clinic are co-located with the Phoenix Indian Center and Native American Connections in a full-service center easily accessible to their target population in central Phoenix. Mr. Murillo concluded by sharing a description of several integrated health care delivery models, and the collaborative and integrated care and practice models of integration.

ADHS/DBHS – Bob Sorce, Assistant Director for Health Care Development, ADHS informed the audience that in order to avoid a repeat of Dr. Laura Nelson’s presentation, he would change his presentation format to an open dialogue session regarding integrated care. The following narrative documents the dialogue between Mr. Sorce and the Forum participants.

*A representative of the Advisory Council on Indian Health Care (ACOIHC) indicated there is a difference in the TRBHAs’ and RBHAs’ reporting capacities. TRBHAs are currently working on capacity building to improve and increase service delivery. A question was posed to Mr. Sorce: Is there a chance that requirements will be reduced for the TRBHAs? Bob Sorce explained the history. The requirements are passed down from CMS and are out of ADHS/DBHS’ control. He further explained the TRBHA IGAs are not completely the same – they are based on each tribal nation’s needs. He noted that ADHS/DBHS hears the same concerns from the RBHAs regarding administrative burdens and reporting. He concluded that ADHS/DBHS is open to suggestions on streamlining the reporting process.*

*The CEO of a NARBHA provider indicated that there is no funding (administrative or reimbursement) for Primary Care Provider (PCP) integration. Incentives need to be provided in order for providers to manage and improve outcomes.*

*A Yavapai Apache Behavioral Health Program representative indicated that tribes have concerns about this issue as eligibility and reimbursement for services stops when the person is incarcerated. He further indicated that alternative treatments and prevention services are not funded. Mr. Sorce shared that this is an AHCCCS eligibility issue where services stop once the client walks through the door. He agreed that coordination of care is needed and there is a need to ensure discharge planning, medication management, and ongoing treatment after discharge, etc. He further noted that prevention is a cornerstone to efforts to improve care delivery.*

*Verde Valley Guidance Center has found that in their experience of providing services to SMIs, effective treatment costs for care is more for higher acuity clients. For example, “no shows” for SMI clients are higher, and are not reimbursable.* Bob Sorce replied that the hallmark of integrated health care is the multidisciplinary team. He further indicated the use of peer support adds to efforts to increase compliance with treatment goals and that costs do increase as additional primary care issues are identified. He emphasized the cost model for integrated health care is based on assumptions, as there is currently no data.

*A Hopi program representative indicated that there is a high need for substance abuse treatment for young pregnant mothers. There still are many challenges and service gaps on reservations.*

*The ADHS/DBHS Tribal Contract Administrator remarked that the planning and implementation of the Maricopa County pilot, ADHS/DBHS needs to ensure partnerships with urban Indians. She recommended the need for a focus on partnering with IHS for integration efforts on rural reservations. American Indians receive their physical care from IHS in rural areas of the state.* Mr. Sorce noted ADHS/DBHS has begun dialogue with IHS regarding coordination of care. He indicated there are privacy issues (HIPAA) in the sharing of service data between the two systems. He highlighted the pilot focuses on Maricopa County and that ADHS/DBHS is aware of the drastic differences in remote areas of the state as compared to Maricopa County. He shared that these differences will be taken into account and ADHS/DBHS will treat each community differently in the planning process.

Gila River Residential Treatment Center, Gila River Health Care Corporation (GRHC) – Cheryl Cuyler, Residential Services Director, *Thwajik Ke* Residential Treatment Center, provided a brief history of the 82-bed facility since it opened in 2007. The Center houses both women and men, including transitional units, and a detox facility. Ms. Cuyler stated the center has been very successful since it’s transition from the GRIC Department of Human Services to the Gila River Health Care Corporation in December, 2010. She indicated they currently employ six (6) independently licensed staff, and have increased their census from 5 to 48 with over 60 successful graduations in 2011. The Center delivers integrated care and is positioned to address behavioral health issues as part of a comprehensive health home model. Primary care, psychiatric services, and nursing care are all provided on-site. Furthermore, the integration of traditional, cultural, and spiritual philosophies as part of the continuum of services was emphasized. Ms. Cuyler emphasized that the Center has improved its capacity to deliver

coordinated and integrated care to clients with complex needs. Education, employment, and prevention issues are also addressed.

Banner Alzheimer's Institute – Filmer Lalio, Native American Program Coordinator, presented on their outreach initiatives for Arizona tribes. He indicated their efforts focus on increasing community awareness, education, collaboration and partnering with health care providers in American Indian communities (i.e., tribal and IHS clinics, CHR, elderly and caregiver programs). The Institute provides training and workshops. He concluded by stating health care providers are becoming more aware and educated regarding Alzheimer's disease and American Indian families are seeking information on the disease and coping with the disease.

Participant Comments/Questions: There were no comments and/or questions for this panel other than the open dialogue with Bob Sorce.

**Telemedicine in Behavioral Health Panel:** Panel participants described their Telemedicine program, accomplishments, plans, and efforts to resolve barriers to utilization and needed improvements to expand telepsychiatry and training to American Indian communities.

Parker Indian Health Center - IHS - Dr. Peter Stuart, Telemedicine Psychiatrist and Mental Health Services Director at the Parker Indian Health Center, began the panel presentations by sharing the history of Telemedicine from an IHS perspective, early challenges of implementing Telemedicine in rural and tribal areas, and lessons learned in implementation at local tribal program sites. He further covered the benefits to the patients and unexpected cost of having a Telemedicine program in a tribal setting. He emphasized that in future development, consideration should include connection to larger programs for more comprehensive coverage, increased use of the Telemedicine system for non-psychiatric providers, and the establishment of standard MOUs for connecting to non-IHS sites, including tribal behavioral and mental health programs and RTCs. Dr. Stuart stressed that the implementation of Telemedicine should be less about the technology and more about the integration of type of service delivery.

Northern Arizona Regional Behavioral Health Authority (NARBHA) – Dr. Sara Gibson, Medical Director, NARBHA Telemedicine Program, provided a brief overview of NARBHA and its service area and further described the purpose for telepsychiatry. She said the focus is on access to care in rural areas, and indicated the need for services are greater than the ability to supply services. Dr. Gibson further noted the benefits of the availability of psychiatric services in rural areas where there is a psychiatric shortage, as well as patients could be treated in their own communities, and the involvement of families in the treatment and support. She also indicated the improvements in recruitment and retention of psychiatric providers preventing travel burnout. She highlighted many other benefits. Dr. Gibson also described some of the

challenges, such as the difficulty to obtain the “real presence” of the patient and the lack of physical “sense” of patients’ condition. She further described the evidence that supports that patients quickly adapt and build a rapport with the Telemedicine provider as they experience a personal benefit in their recovery. In closing, Dr. Gibson outlined some literature that suggests that American Indians accessing services through telemedicine experience patient comfort, satisfaction with services, and cultural acceptance.

Hopi Guidance Center (HGC) – Jon Joshevama, Quality Assurance Program Manager, with the Hopi Guidance Center (HGC), noted that HGC is a tribal provider of NARBHA and a user of the NARBHA Telemedicine system. He described the tribal cultural perspectives on the use of technology in rural, tribal settings and mentioned some benefits of the use of Telemedicine. He displayed a cost analysis, which demonstrated that Telemedicine implementation provides costs savings to the HGC. He summed up by highlighting some value comparisons between Hopi communities and the larger behavioral health system to illustrate potential implementation issues.

Participant Comments/Questions: There were no comments and/or questions for this panel.

**Final Thoughts:** Final thoughts on the two-day forum were provided by Cora-Lei Marquez, Tribal Representative, Yavapai Apache Nation.

**Closing Prayer:** Forum II concluded with a closing prayer provided by James Uqualla, Havasupai Medicine Elder. The Yavapai-Apache Tribal Color Guard retrieved the colors at the Closing.

## **Challenges/ Recommendations**

The following is a summary of challenges and recommendations made by participants and presenters.

### **Challenges:**

- No integrated health IT system in existence.
- Tribal behavioral health programs transition to a corporate board oversight and the necessity/ requirement to develop and implement quality management programs.
- ADHS/DBHS reporting requirements are burdensome and excessive. TRBHAs are not mini-RBHAs and the reporting requirements are applicable to the RBHAs, not the smaller TRBHAs with fewer resources.
- Excessive Quality Management (QM) requirements and reports to ADHS/DBHS.

- Auto enrollment issues are a significant burden for TRBHAs due to the large number of tribal members living off-reservation.
- Administrative oversight by ADHS/DBHS and mandated requirements place burdens on a small TRBHA with very limited resources.
- Funding, geographic remoteness, and lack of access to qualified professionals.
- Establishing a billing system for revenue generation and raising staff professional competencies and capabilities.
- Addressing/meeting the needs of non-Title XIX clients. For example, young men without children are no longer eligible for behavioral health services. They are often in high-risk categories for needed services.
- Lack of AHCCCS billing code for patients/clients in tribal detention centers.

Recommendations:

- ADHS/DBHS needs to consider waiving some of the requirements that are not as applicable for a smaller TRBHA as they are for the larger RBHA system.
- Consideration of the value of and need for cultural competency in working with tribal clients is needed.
- Flexibility in the provision of services is needed for youth in a tribal detention center as they drop off AHCCCS when they are adjudicated. Flexibility could provide opportunities for tribes to coordinate care prior to adjudication.
- Future discussions need to be held regarding early childhood programs including support for expectant mothers. There is a dilemma due to the inability to bill for pre-clinical services. Discussions need to occur on how to accomplish this needed change.
- Conduct meetings to discuss tribal choices of care, to ensure that dialogue on this topic occurs.
- Increased funding is needed to implement integration health care solutions for rural parts of Arizona to increase rural health services.
- Future Telemedicine developments need to include connection to larger program system for more comprehensive coverage.
- Increase use of the Telemedicine system for non-psychiatric providers.
- Establish standard MOUs for connecting to non-IHS sites, including tribal behavioral and mental health programs and RTCs.
- Implementation of Telemedicine should be less about the technology and more about the integration of type of service delivery.

As highlighted in the Challenges and Recommendations section, themes appear to emerge similar to preceding Forum I themes.

- Improving tribal consultation
- Building stronger relationships with tribes
- Building service capacity
- Addressing cultural preference
- Leveraging resources
- Improving access and operations
- Feedback on the Governor's proposal for integrated care

## Attachment 1: List of Forum Attendees

LAST	FIRST	TITLE	AGENCY
Damon	Lafe	Resource Coordinator	Acadia Health Care
Hubbard-Pourier	Lydia	TRBHA Contract Administrator	ADHS/DBHS
Morrison	John	Contract Administrator	ADHS/DBHS
Sorce	Robert	Assistant Director	ADHS/DBHS
Kramer	Dianna	Cultural Competency Manager	ADHS/DBHS
Nelson, MD	Laura	Deputy Director	ADHS/DBHS
Enriquez	Lydia	Administrative Assistant	Advisory Council On Indian Health Care
Hubbard	Fred	Director	Advisory Council on Indian Health Care
Betlach	Tom	Director	AHCCCS
Chicharello	Carol	Tribal Liaison	Arizona Department of Economic Security
Allison	Michael	Native American Liaison	Arizona Department of Health Services
Lalio	Filmer L	Coordinator, NAP	Banner Alzheimer's Institute
Yellowhair	Sheina	Tribal Liaison	Cenpatico Behavioral Health of Arizona
Barbara	Daniel	Executive Director, DH&HS	Colorado River Indian Tribes
McCluskey	Michael	Clinical Director	Colorado River Indian Tribes
McGinnis	Sheila	Community Relations Coordinator	Community Partnership of Southern AZ
Chavez	Julia	Tribal Liaison	Community Partnership of Southern Arizona
Grijalva	Edward	Program Coordinator	Compass Health Care-Tucson
Perez	Betty	Special Population Liaison	Compass Health Care-Tucson
Yepiz	Adam	Crisis Specialist	Crisis Response Center
Deschine	Desirae	Crisis Specialist	Crisis Response Network and Corporation
Nez-Holona	Gen	Clinical Director	DBHS Navajo Nation TRBHA
Vargas, PhD	Pilar	Director, Crisis & Trauma Healing Svcs	EMPACT- Suicide Prevention Program
Brown	Michele	Training Coordinator	EMPACT- Suicide Prevention Program
Wright	Joe	CEO	Encompass Health Services - Tucson
Burggraff	David	Supervisory Psychologist	Ft Defiance - ACU
Descheenie	Beverly	Case Management Specialist	Ft. Defiance Indian Hospital
Lewis	Collette	Behavioral Health Director	Ft. Mojave Behavioral Health
James	Maurice	Acting Director, DH&HS BHS	Ft. Mojave Indian Tribe
Lee	Samantha	Director of Behavior Health	Ganado Sage Memorial Hospital
Cuyler	Cheryl	Director, RTC	Gila River Behavioral Health Program
Foote	Priscilla	Behavioral Health Director	Gila River Health Care Corporation
Green	Steve	CEO	Gila River TRBHA
Joshevama	Jon	Quality Management Coordinator	Hopi Guidance Center
Brehmeyer	David	Special Program Manager	Hualapai Health-Education Wellness
La-Nae	Perci	Medical Social Worker	Indian Health Service - Peach Springs
Flood	Mike	Clinical Social Services Director	Indian Health Service Sells Hospital

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Stuart, PhD	Peter	Mental Health Director	Indian Health Services - Parker Service Unit
Montiel	Alida	Health Systems Analyst	Inter-Tribal Council of Arizona, Inc.
Russell	Kim	AAA Program Specialist	Inter-Tribal Council of Arizona, Inc.
Levine-Mata	Mayday	BH Clinical Director	LA Frontera - Tucson
Clarke, PhD.	Richard	CEO	Magellan Health Services of Arizona
Roybal	Darcy	Tribal Liaison	Magellan Health Services of Arizona
Brown	Wilbur	JPO Prig. Svcs. Staffing Coord.	Maricopa County Juvenile Probation
Schultz	Pamela	Office Sup./Detent. Manager	Maricopa County Juvenile Probation
Baker	Stephanie	Administrative Assistant	Mercy Care - Gilbert
Baker	Evan	Intervention Cardiovascular Tech.	Mercy Care - Gilbert
Wells	Cheri	Tribal Liaison	Northern Arizona Regional Behavioral Health Authority
Moreno	Richard	Director of Behavior Health	Native American Connections, Inc.
Yazzie-Devine	Diana	President-CEO	Native American Connections, Inc.
Robin, PhD	Robert	CEO	Native Americans for Community Action, Inc.
Chavez	Ana	Behavioral Case Manager	Native Health - Phoenix
Etsitty	Shannon	Billing & Coding Specialist	Native Health - Phoenix
Hubbard	Sara	Third Party Program Supervisor	Native Health - Phoenix
Huff	Dennis	Behavioral Health Director	Native Health - Phoenix
Leon	Erinn	Adolescent SA Counselor	Native Health - Phoenix
Murillo	Walter	CEO	Native Health - Phoenix
Philpot	Wendy	Adolescent Therapist/PM	Native Health - Phoenix
Yazzie	Janice	Adolescent Cont. Care Manager	Native Health - Phoenix
Yellowhair	Candice	Case Management Specialist	Navajo Nation DBHS - Kayenta
Gorman	Clara	Case Manager	Navajo RBHA - Chinle
Tsosie	Marsha	Case Management Specialist	Navajo RBHA - Chinle
Toadlena	Martha	Case Management Specialist	Navajo RBHA - Ft. Defiance
King	Lisa	Clinical Specialist Intern	Navajo RBHA - Window Rock
Jackson	Letitia	Case Management Specialist	Navajo RBHA Tuba City
Tom	Patricia	Case Management Specialist	Navajo RBHA Winslow
Lester	Minnie	Case Management Specialist	Navajo RBHA-Dilcon
Lowman	Paul	Case Manager	Navajo RBHA-Kaibato
Gibson	Sara	Telemedicine Director	Northern Arizona Regional Behavioral Health Authority
Hartgroves	Laura	Director, Provider and Network Svcs	Northern Arizona Regional Behavioral Health Authority
Pattinson, PhD	Mick	CEO	Northern Arizona Regional Behavioral Health Authority
Mooney	Warren	Medicine Man	Oklevueha Native American Church
Salgado	David	Coordinator	Parc Place Adolescent Residential Treatment
Cory	Clare	Program Director, CSP	Pascua Yaqui Tribe
Claus, PhD	Cynthia	Director, OHP	Phoenix Area Indian Health Service



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McIntyre, PhD	Dave	Mental Health Consultant	Phoenix Area Indian Health Service
Molina, MD	John	CEO	Phoenix Indian Medical Center
Webb	Charlotte	Director of Recovery	PSA-Behavioral Health Agency
Godfrey	John	Assistant Director of HHS	Salt-River Pima-Maricopa Indian Community
Pavatea	Myrna	Division Director of BHS	Salt-River Pima-Maricopa Indian Community
Taylor-Disir, MD	Monica	Psychiatrist, HHS Clinical Svcs Prog	Salt-River Pima-Maricopa Indian Community
Wesley	Phyllis	Program Manager, Youth Home	San Carlos Apache Tribe
Wilshire, PhD	Thea	Clinical Director, Wellness Center, DH&HS	San Carlos Apache Tribe
Powers, MD	Pamela	Psychiatrist	Self employed
Shoemaker	Jarrett	Community Liaison	Sequel Care of AZ
Zantopp	Michael	Utilization Manager	The Guidance Center
Bowman	Barry	Clinical Supervisor, DH&HS	Tohono O'odham Nation
Henry	Leona	Counselor, DH&HS	Tohono O'odham Nation
Homer	Juanita	Behavioral Health Director, DH&HS	Tohono O'odham Nation
Sampson	David	APS Clinical Director, DH&HS	Tohono O'odham Nation
Nye, MD	Patricia	Behavioral Health Consultant	Tucson Area Indian Health Service
White, PhD	Cynthia	Medical Director	VA Hospital - Prescott
Phelan	Cheryle	Suicide Prevention Coordinator	VA Prescott
Dehnert	Richard	Community Relation Coordinator	Verde Valley Guidance Center
Roderick	Scott	Children's Program Director	Verde Valley Guidance Center
Bondurant	Monty	Adult Program Coordinator	Verde Valley Guidance Center Inc.
Cartia	Robert	CEO	Verde Valley Guidance Center Inc.
GreyWolf	Joseph	Fiscal Agent	Walk-N- Balance Center Inc.
Rick	Ayanvli	Fiscal Agent	Walk-N- Balance Center Inc.
Aday	Noreen	Board Chairperson	White Mountain Apache Behavioral Services, Inc.
Arnett	Bill	CEO	White Mountain Apache Behavioral Services, Inc.
Cromwell	Xena	Board of Directors	White Mountain Apache Behavioral Services, Inc.
Kayson	Bonnie	Board Member	White Mountain Apache Behavioral Services, Inc.
MCune	Robin	Adolescent Case Manager	White Mountain Apache Behavioral Services, Inc.
Numkena	Doreen	BH Program Manager	White Mountain Apache Behavioral Services, Inc.
Prince	Brett	Children and Adolescent Sup.	White Mountain Apache Behavioral Services, Inc.
West	Darwin	Clinical Director	White Mountain Apache Behavioral Services, Inc.
Hamilton	Charlene	Executive Director, DH&HS	White Mountain Apache Tribe
Evan	Linda	Tribal Councilwoman/ASA Case Manager	Yavapai-Apache Nation
Marquez	Cora-Lei	Tribal Representative	Yavapai-Apache Nation
Hicks	Alan	Program Manager	Yavapai-Apache-Nation Behavioral Health Program

## Attachment 2: Forum Agenda (amended)

### Statewide Arizona American Indian Behavioral Health Forum II “Policy and Service Delivery in a Changing Environment”

February 15, 2012:

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6:30 a.m.	Restaurant Open	
7:15 a.m.	Registration	Hotel Lobby
	Continental Breakfast	Sedona Room
8:00 a.m.	Welcome	<b>Fred Hubbard, Master of Ceremonies</b> <i>Executive Director, AZ Advisory Council on Indian Health Care</i>
	Opening Prayer	<b>Don Decker</b> <i>Apache Spiritual Leader</i>
	Posting of Colors	<b>Yavapai-Apache Tribal Color Guard, Larry Jackson</b>
8:30 a.m.	Opening Remarks	<b>Linda Evan</b> <i>Councilwoman, Yavapai Apache Nation</i>
		<b>Honorable David Kwait</b> <i>Chairman, Yavapai-Apache Nation</i>
	Eagle Feather Sponsor Comments	
		<i>Northern Arizona Regional Behavioral Health Authority (NARBHA)</i>
		<i>Verde Valley Guidance Clinic</i>
		<i>Pascua Yaqui TRBHA</i>
		<i>Gila River TRBHA</i>
	ADHS Welcome	<b>Michael Allison</b> <i>Native American Liaison, ADHS</i>
9:00 a.m.	Forum I Report	<b>Lydia Hubbard-Pourier</b> <i>TRBHA Contract Administrator, ADHS/DBHS</i>
9:20 a.m.	Forum II Objectives	<b>Alida Montiel</b> <i>Health System Analyst, Inter Tribal Council of Arizona, Inc.</i>
9:40 a.m.	Budget and Economic Overview	<b>Tom Betlach</b> <i>Director, AHCCCS</i>
10:15 a.m.	Break	
10:30 a.m.	RBHA Panel Presentations	<b>Lydia Hubbard-Pourier, Moderator</b> <i>ADHS/DBHS</i>
	Panel Members:	
		<i>Cheri Wells, Tribal Liaison, NARBHA</i>
		<i>Darcy Roybal, Tribal Liaison, Magellan Health Services of Arizona</i>
		<i>Sheina Yellowhair, Tribal Liaison, Cenpatico of Arizona</i>
		<i>Julia Chavez, Tribal Liaison, Community Partnership of Southern Arizona</i>

Statewide Arizona American Indian Behavioral Health Forum II  
Final Report

<b>11:45 a.m.</b>	<b>Box Lunch</b>	<i>Sedona Room/Patio</i>
<b>1:00 p.m.</b>	<b>TRBHA Panel Presentations</b>	<b>Lydia Hubbard-Pourier, Moderator</b> <i>ADHS/DBHS</i>
	Panel Members:	
	Gen Holona, <i>Clinical Director, Navajo Nation TRBHA</i>	
	Dr. Bill Arnett, <i>CEO, Apache Behavioral Health</i>	
	Steven Green, <i>TRBHA CEO, Gila River Health Care</i>	
	Priscilla Foote, <i>Director, Behavioral Health Services, Gila River Health Care</i>	
	Dr. Clare Cory, <i>Program Director, Centered Spirit Program, Pascua Yaqui Tribe</i>	
<b>2:15 p.m.</b>	<b>Tribal/638/Urban Panel</b>	<b>Diana Kramer, Moderator</b> <i>Cultural Competency Manager, ADHS/DBHS</i>
	Panel Members:	
	Thea Wilshire, PhD, <i>Clinical Director, Wellness Center, San Carlos Apache Tribe</i>	
	David Brehmeyer, <i>Special Projects Program Manager, Health Education &amp; Wellness Department, Hualapai Tribe</i>	
	Robert Robin, PhD, <i>CEO, Native Americans for Community Action, Inc.</i>	
<b>3:30 p.m.</b>	<b>Break</b>	
<b>3:45 p.m.</b>	<b>Indian Health Service</b>	<b>Dr. Patricia Nye</b> <i>Psychiatrist, Tucson Area Office, Indian Health Service</i>
	IHS Implementation of the Indian Health Care Improvement Act Permanent Reauthorization— Title VII, Behavioral Health Services & Related Provisions	
<b>4:15 p.m.</b>	<b>Open Dialogue</b>	<b>Fred Hubbard</b> <i>Director, Advisory Council on Indian Health Care (ACOIHC)</i>
<b>4:45 p.m.</b>	<b>Summary of Day One</b>	<b>Fred Hubbard</b> <i>ACOIHC</i>
<b>5:30 – 7:00 p.m.</b>	<b>Reception with Informal Buffet Meal</b>	<i>Sedona Room</i>
	<b>Recognition of T/RBHA CEOs &amp; Forum Sponsors</b>	<b>Fred Hubbard, Master of Ceremonies</b>
	<b>Cultural Presentation</b>	<b>James Uqualla</b> <i>Havasupai Medicine Elder</i>
	<b>Yavapai Bird Singers</b>	

**February 16, 2012:**

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<b>6:30 a.m.</b>	<b>Restaurant Open</b>	
<b>7:30 a.m.</b>	<b>Registration</b>	<i>Hotel Lobby</i>
	<b>Continental Breakfast</b>	<i>Sedona Room</i>
<b>8:00 a.m.</b>	<b>Welcome and Day Two Schedule</b>	<b>Michael Allison</b> <i>ADHS</i>
<b>8:15 a.m.</b>	<b>Status of State Behavioral Health Program &amp; Health Integration</b>	<b>Dr. Laura Nelson</b> <i>Deputy Director, Division of Behavioral Health Services, ADHS</i>
<b>9:00 a.m.</b>	<b>Integrated Health Panel</b>	<b>Carol Chicharello, Moderator</b> <i>Tribal Relations Liaison, Arizona Department of Economic Security</i>
	Panel Members:	
	Dr. John Molina, <i>CEO, Phoenix Indian Medical Center</i>	
	Walter Murillo, <i>CEO, Native Health</i>	
	Bob Sorce, <i>Assistant Director, ADHS/DBHS</i>	
	Cheryl Cuyler, <i>Director, RTC, Gila River Health Care</i>	
	Filmer Lallo, <i>Native American Program Coordinator, Banner Alzheimer's Institute</i>	
<b>10:30 a.m.</b>	<b>Break</b>	
<b>10:45 a.m.</b>	<b>Telemedicine in Behavioral Health Panel</b>	<b>Cheri Wells, Moderator</b> <i>NARBHA</i>
	Panel Members:	
	Dr. Peter Stuart, <i>Mental Health Director, Colorado River Service Unit, Parker Indian Health Center</i>	
	Dr. Sara Gibson, <i>Associate Medical Director, Medical Director Telemedicine, NARBHA</i>	
	Jon Joshevama, <i>Quality Assurance Program Manager, Hopi Guidance Center</i>	
<b>11:45 p.m.</b>	<b>Final Thoughts</b>	<b>Cora-Lei Marquez</b> <i>Tribal Representative, Yavapai Apache Nation</i>
<b>12:00 p.m.</b>	<b>Closing Prayer</b>	<b>James Uqualla</b> <i>Havasupai Medicine Elder</i>
	<b>Retiring of Colors</b>	<b>Yavapai-Apache Tribal Color Guard, Larry Jackson</b>

### Attachment 3: Planning Committee Members

<b>Michael Allison</b> , Co- Chair, Native American Liaison, Arizona Department of Health Services
<b>Lydia Hubbard-Pourier</b> , Co-Chair, Tribal Contract Administrator, ADHS/DBHS
<b>Alan Hicks</b> , Behavioral Health Counselor, Yavapai-Apache Nation
<b>Dr. Clare Cory</b> , Program Director, Center Spirit Program, Pascua Yaqui Tribe
<b>Albert Long</b> , Senior Program & Project Specialist, Navajo Department of Behavioral Health Services, Navajo Nation
<b>Gen Holona</b> , Clinical Director, Navajo Department of Behavioral Health Services, Navajo Nation
<b>Priscilla Foote</b> , Behavioral Health Director, Gila River Health Care Corporation
<b>Dennis Huff</b> , Behavioral Health Director, Native Health
<b>Alida Montiel</b> , Health System Analyst, ITCA, Inc.
<b>Dr. Patricia S. Nye</b> , Behavioral Health Consultant, Tucson Area Indian Health Service
<b>Cheri Wells</b> , Tribal Liaison, Northern AZ Regional, Behavioral Health Authority
<b>Sheina Yellowhair</b> , Tribal Liaison, Cenpatico Behavioral Health of AZ
<b>Darcy Roybal</b> , Tribal Liaison, Magellan Health Services of AZ
<b>Julia Chavez</b> , Tribal Liaison, Community Partnership of Southern AZ
<b>Fred Hubbard</b> , Executive Director, Advisory Council on Indian Health Care
<b>Lydia Enriquez</b> , Administrative Assistant, Advisory Council on Indian Health Care
<b>Carol Chicharello</b> , Tribal Relations Liaison, AHCCCS
<b>Filmer Lalio</b> , Native American Coordinator, Banner Alzheimer's Institute
<b>Linda Evans</b> , Councilwoman, Yavapai-Apache Nation
<b>Cora-Lei Marquez</b> , Tribal Representative, Yavapai-Apache Nation

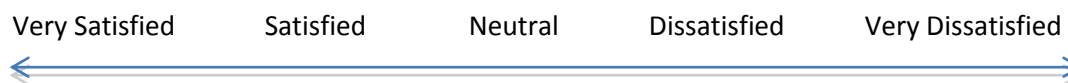
## Attachment 4: Evaluation Feedback Summary

### Introduction:

This attachment summarizes the results of the evaluation forms completed by participants of the American Indian Behavioral Health Forum II - *Policy and Service Delivery in a Changing Environment*. The evaluation form contained a number of questions regarding select elements of the forum from the forum venue and location to the quality of presenters. The planning committee sought to measure the success of the forum and aimed questions at eliciting responses to identify elements for improvement. The evaluation findings will be considered when planning for Forum III. The evaluation form was divided into two main sections: closed-end and opened-ended questions. Approximately 46 forum participants submitted completed evaluations.

### Section I: Respondents' Perceptions of Forum Characteristics

The first section of the evaluation was composed of 10 categories. Attendees were asked to express their degree of satisfaction or dissatisfaction based on the following scale.



For purposes of this summary, the responses to the ten categories in the first section have been divided into the following: (1) *Overall Forum Satisfaction*; (2) *Forum Logistics*; and, (3) *Forum Presentations & Content*.

Positive responses (highlighted in blue on the following exhibits) refer to responses of “*very satisfied*” and “*satisfied*.” Neutral responses refer only to responses of “*neutral*.” Negative responses refer to responses of “*dissatisfied*” and “*very dissatisfied*.”

#### ***Overall Forum Satisfaction:***

The respondents reported positively (96%) in their satisfaction of the Forum, displayed in Exhibit A.

#### ***Forum Logistics:***

As shown in Exhibit B, the majority (approximately 76%) of respondents were either “*very satisfied*” or “*satisfied*” with the scheduled date of the forum. About 20% of respondents indicated that they were neutral to the scheduled date of the forum. Only 5% indicated that there were dissatisfied with the date of the forum.

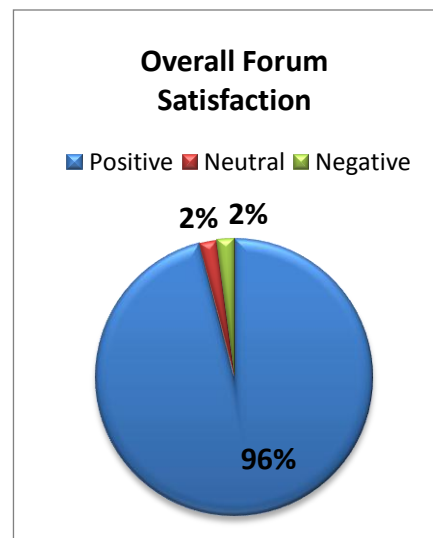


Exhibit A – Overall Conference Satisfaction

Most respondents expressed satisfaction with the forum venue and location (Exhibit C & D), 95% and 93%, respectively.

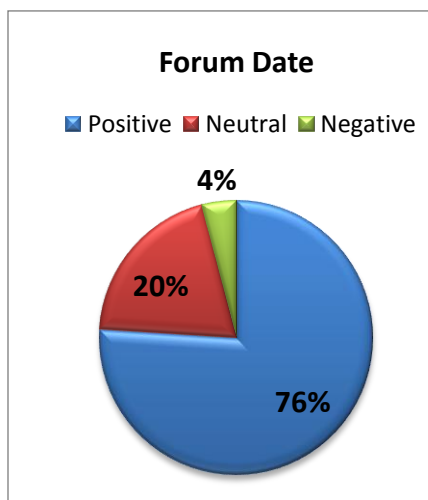


Exhibit B – Forum Date

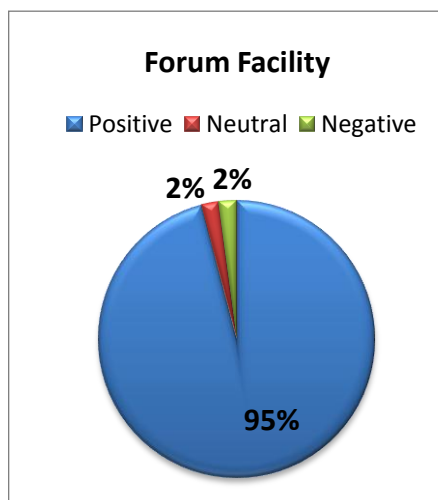


Exhibit C – Forum Facility

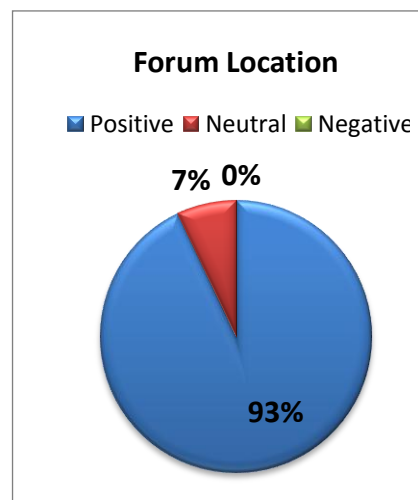


Exhibit D – Forum Location

In terms of publicity level (Exhibit E), approximately 70% of respondents specified they were “very satisfied” or “satisfied” with the publicity level of the forum. About 23% were “neutral” on the matter and only 7% of respondents were “dissatisfied” at some level.

The majority of respondents (approximately 76%) indicated they were “very satisfied” or “satisfied” with the convenience of registration (Exhibit F). The remaining 24% of respondents were “neutral” on the matter.

As illustrated in Exhibit G, the majority of respondents (approximately 88%) reported that they were either “very satisfied” or “satisfied” with the registration fees for the forum. The remaining 12% remained “neutral.”

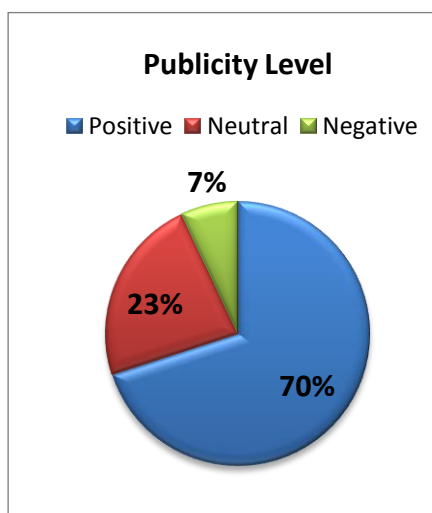


Exhibit E – Publicity Level

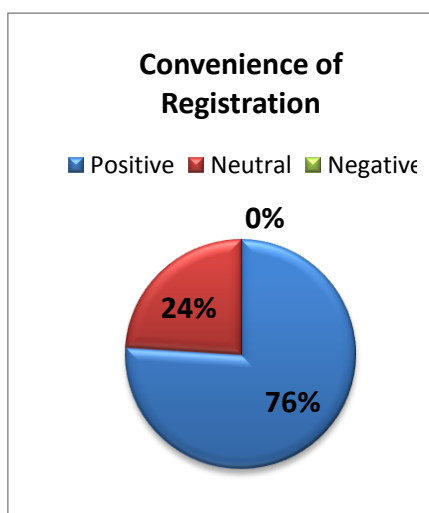


Exhibit F – Convenience of Registration

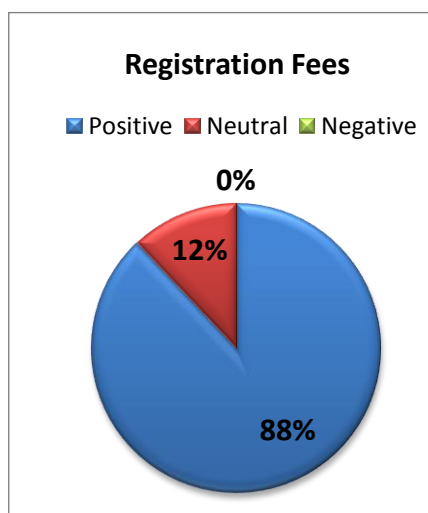


Exhibit G – Registration Fees

### **Forum Presentations & Content**

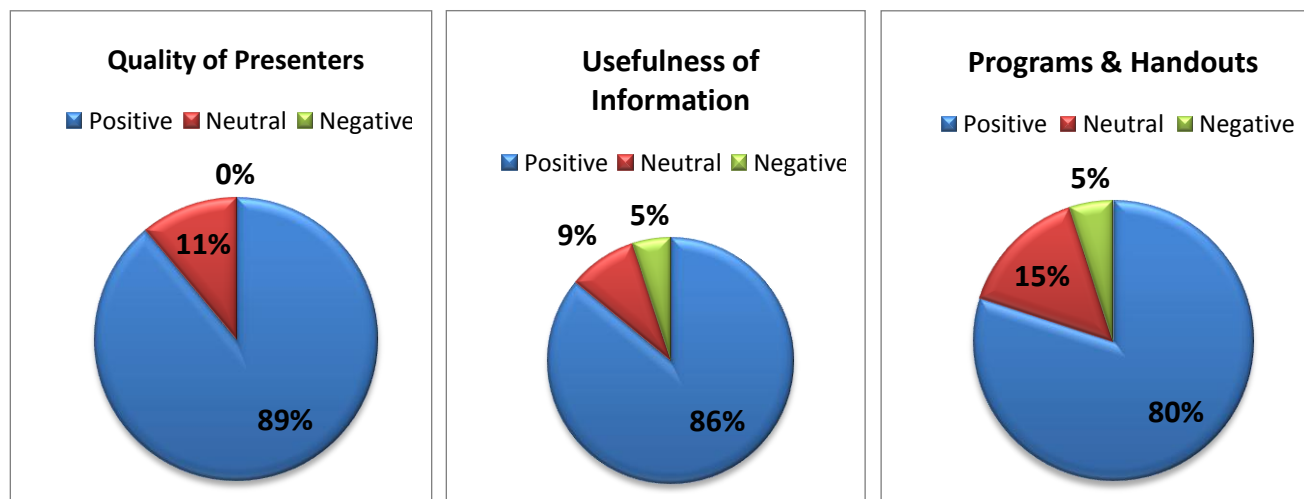


Exhibit H – Quality of Presenters

Exhibit I – Usefulness of Information

Exhibit J – Programs & Handouts

The majority (about 89%) of respondents expressed they were “very satisfied” or “satisfied” on the quality of presenters. No “dissatisfaction” was denoted on the quality of presenters (Exhibit H).

In terms of the usefulness of information, most respondents (approximately 86%) specified that they were “satisfied” (Exhibit I). Only 5% were “dissatisfied” at some level. Similarly participants (about 80%) responded positively on the programs and handouts, while about 5% reported their “dissatisfaction” (Exhibit J).

### **Section II: Respondents’ Recommendations & Other Comments**

The second section of the evaluation form was comprised the following three open-ended questions.

1. What suggestions would you like to make for a future Forum?
2. What might be helpful follow-up from the Forum II?
3. Other/Additional Comments

The responses collected from the evaluation forms are summarized and grouped by subject matter according to the following characteristics:

- Forum Length and Format
- Forum Venue, Location & Accommodations
- Breakout Sessions
- Timeliness
- Reception



- Food & Beverage
- Convenience of Registration
- Level of Publicity
- Programs & Handouts
- Quality of Presenters
- Presentation Content & Usefulness of Information
- Recommendations for Future Presenters/Speakers
- Recommendations for Future Topics
- Follow-Up Activities
- Other Comments

#### ***Forum Length and Format -***

In terms of the overall length, some respondents reported that the forum should be longer than 1 ½ days because there appeared to be time restraints given the many topics that were discussed. Many respondents expressed that the forum format should have less presentations and more time for participants to have meaningful discussions regarding the concerns at hand. Additionally, some respondents suggested that there be small group discussions and formulated recommendations.

In terms of the overall forum, it was recommended that the speakers be more sensitive when telling jokes so as not to offend tribes or individuals. In addition, it was recommended that ADHS executives participate more than a ½ day in order to attain a better understanding of the spirit of the conference.

#### ***Forum Venue, Location & Accommodations -***

In terms of the forum facility, there were recommendations for:

- Larger meeting space;
- Better microphone/PA system;
- Better visibility by adding a camera image of the presenter; and,
- Adjustment of room temperature.

Overall, the venue and location garner high praises as shown in first section. The respondents again expressed that the venue was excellent and the accommodations were close. A recommendation was made the next forum be hosted at Hon-Dah (White Mountain Apache Reservation). Another recommendation is to move the forum venue to various tribal lands so participants can learn about diverse tribal cultures.

#### ***Breakout Sessions -***

Respondent's breakout session comments centered on the need for timeliness and more discussion among providers and the T/RBHAs. One respondent requested more training and less updates.

#### ***Timelines -***

Many recommendations by respondents were made to stay on schedule. Moreover, recommendations made to shorten some of the presentations and allot more time for questions and answers.

***Reception -***

Respondents commended the presentation, presenters, entertainment, and food was excellent.

***Food & Beverage -***

Comments were made the refreshments were tasty, but that more healthy snacks be considered. The respondents commended the quality of the reception meal was excellent.

***Convenience of Registration -***

It was recommended that the registration process and set-up be organized better.

***Level of Publicity -***

One respondent commented to open the forum to non-Indian network providers.

***Programs & Handouts -***

Respondent conveyed the need for the distribution of an electronic and hardcopy of the updated participant list and presentations, following the conclusion of the forum. Respondents did share their appreciation for the conference binders and their contents.

***Quality of Presenters -***

Respondents bestowed high praise on the presenters. Many respondents expressed satisfaction with the presentations and the presenters' level of knowledge of the topics. A minimal number of respondents commented presentation delivery could be improved for certain presenters, as well as presenters keeping presentations to the time allotted.

Some of the respondents expressed signified concern that ADHS executives were not able to have a genuine discussion with participants regarding issues related to behavioral health.

***Presentation Content & Usefulness of Information -***

Respondents reported the presentations were very good and informative. Moreover, they commented the challenges experienced and discussed by individual programs were very helpful. The respondents denoted the panel presentation discussions were very positive and one respondent made particular note of the TRBHA panel. Another respondent indicated the integrated health panel could be strengthened. It was expressed the difficulty for a respondent to relate to presentations regarding outpatient and medical services, as they are not provided by their program.

Several comments were made of the AHCCCS budget presentation provided. Overall, feedback regarding the presentation was good, but respondents specified the need for more information on tribal reimbursement and billing. In addition, concern was expressed on the eligibility for childless adults ages 18-50, primarily because of the need for substance abuse rehabilitation and other services among this population.

#### ***Recommendations for Future Presenters/Speakers -***

Recommendations for future speakers and presenters were shared. It was recommended IHS representation on the tribal/urban panel and/or as an IHS direct care behavioral health facility service provider. Inclusion of tribal leaders as speakers was recommended. A respondent requested a presentation by a Native American medicine person who works with incarcerated people.

#### ***Recommendations for Future Topics -***

Respondents suggested the following topics for future forums.

- Cultural sensitivity, awareness, and integration of values
- Case study recommendations
- Peer-centered services
- Juvenile mental health services; available child and adolescent services; juvenile early intervention programs (birth to 17), anger management, substance abuse, detained youth, AHCCCS suspensions and needed services and care coordination
- Telepsychiatry and other emerging trends
- Rural tribal services; consideration of rural problems, i.e. transportation, case management, home care, alcohol issues, etc.
- TRBHA-specific session
- RBHA success stories
- Trans generational trauma and dependency
- Funding status of 2014
- Affordable Care Act behavioral health changes
- AHCCCS tribal reimbursement and tribal billing specifics; AHCCCS changes as the program evolves and its impact on the RBHA
- Pressing Issues and Solutions (Example: AHCCCS eligibility for single individuals and incarcerated individuals seeking help)

#### ***Follow-Up Activities -***

Respondents were asked to specify any follow-up activities that should occur after the forum. A number of follow up activities were requested as follow:

- Report a timeline, method to measure success, actual success, and topics submitted to the ADHS;

- Provide a status of ADHS and AHCCCS in FY 2012 and FY 2013;
- Follow-up on T/RBHA, urban program, and tribal program advancements or barriers. As well as issues with coordination and continuation of services for juvenile placements off-reservation and general reimbursement topics;
- Share updates on urban and tribal programs;
- Improve collaboration between IHS and urban Native services;
- Send thank you notes to attendees;
- Send e-mail or post any missing presentations and notes from the sessions; and,
- Send out attendees contact information of attendees, including name, agency, and e-mail address.

***Other Comments -***

The following are insightful comments and observations that were made, but did not fit in a particular category previously mentioned.

- Appreciated the limited amount of participants
- High-level participants who can change the system were present
- It appears that Indian Country has similar challenges
- It was great to see unity between tribal entities
- Empowering peers strengthens the system
- Great to hear accomplishments of others
- Many thanks for all of your hard work

The planning committee is appreciative of all the responses and comments submitted by respondents. All comments will be fully considered by the planning committee in preparation for the next forum.

## **Attachment 5: List of Abbreviations**

638	P.L. 93-638 contracted Tribal health facility
ACOIHC	Arizona Advisory Council on Indian Health Care
ADHS/DBHS	Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS	Arizona Health Care Cost Containment System
AI	American Indians
ALTCS	Arizona Long Term Care System
BIA	Bureau of Indian Affairs
CARF	Commission on Accreditation of Rehabilitation Facilities
CMS	Centers for Medicare and Medicaid Services
CPSA	Community Partnership of Southern Arizona
EHR	Electronic Health Record
GRHCC	Gila River Health Care Corporation
GRIC	Gila River Indian Community
GSA	Geographic Service Area
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IGA	Intergovernmental Agreement
IHS	Indian Health Service
IT	Information Technology
ITCA	Inter Tribal Council of Arizona
MOU	Memorandum of Understanding
NARBHA	Northern Arizona Regional Behavioral Health Authority
NIHB	National Indian Health Board

PCP	Primary Care Provider
PIMC	Phoenix Indian Medical Center
QM	Quality Management
RBHA	Regional Behavioral Health Authority
RTC	Residential Treatment Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SMI	Seriously Mentally Ill
TRBHA	Tribal Regional Behavioral Health Authority
UIHP	Urban Indian Health Program
WMABHS	White Mountain Apache Behavioral Health Services
WMAT	White Mountain Apache Tribe

**ARIZONA DEPARTMENT OF HEALTH SERVICES/DIVISION OF  
BEHAVIORAL HEALTH SERVICES 1/18/2012 STATEWIDE  
BEHAVIORAL HEALTH TRIBAL CONSULTATION MEETING REPORT**

PREPARED BY  
Michael Allison  
Native American Liaison  
Office of the Director



June 15, 2012

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## 1/18/2012 Behavioral Health Tribal Consultation Meeting Summary

### Attendance:

The meeting was held in Conference Rooms 215 A&B of the Arizona Department of Health Services (ADHS) 150 N. 18<sup>th</sup> Avenue office building in Phoenix. Thirty-four participants participated with twenty-three in person at ADHS and eleven at telemedicine sites located at three Indian Reservation sites (Hualapai, Hopi and Gila River) and two Regional Behavioral Health Authority (RBHA) sites (Flagstaff and Tucson). See Attachment One and Two for a Listing of Participants and the Meeting Agenda.

### Welcome, Blessing, and Opening Comments:

Michael Allison (Navajo), Native American Liaison, at ADHS, provided the opening comments and functioned as the meeting Master of Ceremony. Filmer Lalio (Pueblo of Zuni), Coordinator, Native American Program, Banner Alzheimer's Institute, gave the traditional blessing. Will Humble, Director, ADHS provided additional welcoming remarks and provided an update on the status of integrated care contracting. The first draft of licensing regulations may be ready by April, 2012. Efforts are underway to initiate the RFP process for the RBHA contract for Maricopa County. The following question/comments were made and asked by Tribal representatives with replies from Will Humble:

Reuben Howard, Executive Director, Health Services Division, Pascua Yaqui Tribe commented that there should be reduction of requirements for Tribes due to smaller infrastructure and licensing requirements are duplicative. Will Humble replied he was open to discuss deemed status and other alternative options.

Loren Sekayumtewa, Director, Hopi Guidance Center commented that the approach must be unique to each Tribe. Tribes have recruitment & retention challenges and there are auto-enrollment issues, etc. Will Humble ask Mr. Sekayumtewa to put his comment/concerns into writing and he asked Michael Allison to follow up with Loren.

### Block Grants Presentation, Discussion and Recommendations:

Michael Sheldon, Manager, Office of Data Reporting & Analysis, ADHS-Division of Behavioral Health Services (DBHS) gave a power point presentation on the joint application process for the Substance Abuse Prevention and Treatment Block Grant (SAPT) and the Community Mental Health Services Block Grant (CMHS). The services cannot be Medicaid reimbursable services. The following question/comments were made with replies from ADHS staff.

Reuben Howard commented that the \$9-9 ½ million for the joint application should be based on need and traditional medicine should be allowed. Ann Froio, Assistant Director, ADHS-DBHS commented that the methodology for determining need must be developed and she did not see why traditional medicine could not be included.

## 1/18/2012 Behavioral Health Tribal Consultation Meeting Summary

Al Long, Senior Program and Project Specialist, Navajo Division of Health, Department of Behavioral Health asked why the Tribes were not consulted prior to ADHS submitting the joint application. Ann Froio apologized for this situation. She stated ADHS is committed to Tribal Consultation.

Dr. Bill Arnet, Director, Apache Behavioral Health Services, Inc. commented that TRBHAs could potentially get more funding based on needs. Ann Froio answered that this was a possibility based on documentation. Michael Sheldon commented that ADHS lacks American Indian total data.

Alida Montiel, Health System Analyst, Inter Tribal Council of Arizona, Inc. commented that there is a need for a Needs Methodology System because Tribes, Indian Health Service (IHS) and urban Indian information is lacking in the state data system. Giving the timeframe there might be a case to hire a consultant to work on the methodology. Ann Froio commented that this was a good suggestion. Lydia Hubbard-Pourier, TRBHA Contract Administrator, ADHS-DBHS commented that the challenge will be obtaining data from the 638 programs as they receive Medicaid payment through an all inclusive rate and do not have utilization rates. Michael Sheldon commented he could support the hiring of a consultant.

Loren Sekayumtewa commented that there is a need to invest dollars to determine the methodology. There are substance abuse and mental health dual diagnoses, domestic violence, elder abuse, etc. There is no higher level of care available on the reservations. There is a lack of cultural competency with RBHA providers. There is also a need for long term care. Needs are not being met. Ann Froio requested Mr. Sekayumtewa to put his comments into writing.

Reuben Howard commented that there is a need for Tribal input into the RBHA service delivery. He recommended a Working Group. Ann Froio and Michael Shelton agreed with this recommendation.

Al Long commented that he supports the Work Group recommendation. He also supported Loren Sekayumtewa's priority suggestion. Methodology need is beyond just ADHS. It includes IHS and SAMHSA. Michael Sheldon commented on the need to document undocumented needs.

Alida Montiel asked if a survey would be useful. Michael Sheldon commented he would support a survey approach.

Steve Green, CEO, Gila River Indian Community TRBHA commented that he supports the recommendation for a Tribal Work Group to work on methodology development.

Carol Chicharello, Tribal Relations Liaison, Arizona Department of Economic Security commented on the billing system and said that IHS is the payer of last resort for Indian people. Michael Sheldon commented that ADHS is payer of last resort per the grant guidelines. Ann Froio commented that this issue needs to be researched.

Coordination of Care Services, Discussion and Recommendations

Robert Sorce, Assistant Director, Health Care Development, ADHS-DBHS provided comments on the creation of a new ADHS-DBHS office called the Health Care Development. He provided a presentation on the background and status of the Maricopa County RBHA RFP. It is a new model for integrated health care for Seriously Mentally Ill patients/clients. ADHS is drafting revised behavioral health licensing rules to allow for integrated care. The current Magellan contract has been extended for one additional year to 10/01/2013. The new RFP should be issued during the summer of 2012. Per the Affordable Care Act health information exchanges must be established and everyone must have health coverage. The Supreme Court will soon hear the states' suit against the Affordable Care Act. The following questions and comments were made with ADHS staff answers:

Reuben Howard asked how electronic medical records would be handled and how the new Maricopa County RFP would effect on and off reservation American Indians. Robert Sorce commented that electronic medical records apply to all patient care, not just for behavioral health and that ADHS-DBHS is partnering with Magellan without any extra dollars for Magellan. Planning is not that far along to answer the on and off reservation question. He added that feedback is needed from everyone.

Steven Green commented that the Gila River Indian Community is already doing integration successfully.

Alida Montiel commented that ADHS needs to reach out to Maricopa County Tribes. Bob Sorce commented that the ADHS Raise Your Voice effort was to obtained community input.

Loren Sekayumtewa commented that there is a need to consider urban Indians in ADHS planning. American Indians are not included up front as is required. There is a difference between American Indian and non-Indian definition of mental health. There is a need for capacity building support for Tribes. There is a need for system compatibility. Due to state cuts to AHCCCS non-eligible AHCCCS American Indian patients are turning to IHS for care. Robert Sorce commented he was supportive of Mr. Sekayumtewa's comments. AHCCCS service cuts are also impacting non-Indian patients. He added that in 2014 per the Affordable Care Act, the Medicaid eligibility will be 133% of poverty.

Alida Montiel commented that the team delivery of service provides better care. There is a need for screening tools. Who will do outreach to the Tribes? Robert Sorce agreed with Ms Montiel's comments. Tools are still under development. ADHS will do Tribal outreach.

Al Long commented that treatment must include traditional medicine and other patient choice including faith based treatment. There needs to be outreach to IHS, other federal agencies and PL 93-638 Tribal contracted programs. Robert Sorce commented that some services are not reimbursable and that SAMHSA and CMS are aware and involved.

Closing Remarks

Ann Froio commented that this Tribal Consultation Meeting was long overdue to start our dialogue. She thanked everyone for their participation. Michael Allison commented that he would be preparing a report documenting the proceedings and outcome of the meeting and that he would be following up on the Work Group recommendation. Prior to finalization of the meeting report he would provide a draft to all participants noted as making comments. In response to a question from Alida Montiel, Ann Froio commented that ADHS-DBHS Behavioral Health Tribal Consultations would be held on at least an annual basis.

Dr. Laura Nelson, Deputy Director, ADHS-DBHS introduced Jon T. Perez, Regional Administrator, Region IX, SAMHSA. Mr. Perez expressed appreciation for the opportunity to make comments to the meeting participants. The participants requested that he follow up on two topics. The first was the proposed White House recommendation to include \$50 million for American Indian/Alaska Native SAMHSA grants. The second was the payer of last resort for SAPT and CMHS grants. He stated he would follow up and provide the results of his findings to Dr. Nelson and Michael Allison.

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Jodi	Fredrick	Adult Services Manager	Community Partnership of Southern Arizona

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**BEHAVIORAL HEALTH TRIBAL CONSULTATION MEETING**

Arizona Department of Health Services (ADHS)  
Division of Behavioral Health Services  
Conference Rooms 215A&B  
150 N. 18<sup>th</sup> Avenue  
Phoenix, Arizona  
1/18/12  
1:00 – 4:30pm

Call in Number 1-800-959-1063 x7820, Conference Number 1234  
Telemedicine Participation at NARBHA in Flagstaff and CPSA in Tucson

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| 1:00 – 1:30pm | Welcome, Blessing, Opening Comments<br><br>Michael Allison, Native American Liaison, ADHS<br>Filmer Lalio, Pueblo of Zuni Member<br>Will Humble, Director, ADHS  |
| 1:30 – 3:00pm | Block Grants Presentation, Discussion and Recommendations<br><br><ul style="list-style-type: none"><li>• Substance Abuse Prevention and Treatment</li><li>• Community Mental Health</li></ul><br>Michael Sheldon, Manager, Office of Data Reporting & Analysis, DBHS |
| 3:00 – 3:15pm | Break  |
| 3:15 – 4:30pm | Coordination of Care Services, Discussion and Recommendations<br><br>Robert Sorce, Assistant Director, Health Care Development, DBHS   |
| 4:30pm        | Closing Remarks, Adjournment<br><br>Dr. Laura Nelson, Deputy Director, DBHS  |

**ARIZONA DEPARTMENT OF HEALTH SERVICES/DIVISION OF  
BEHAVIORAL HEALTH SERVICES 1/18/2012 STATEWIDE  
BEHAVIORAL HEALTH TRIBAL CONSULTATION MEETING REPORT**

PREPARED BY  
Michael Allison  
Native American Liaison  
Office of the Director



June 15, 2012

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## 1/18/2012 Behavioral Health Tribal Consultation Meeting Summary

### Attendance:

The meeting was held in Conference Rooms 215 A&B of the Arizona Department of Health Services (ADHS) 150 N. 18<sup>th</sup> Avenue office building in Phoenix. Thirty-four participants participated with twenty-three in person at ADHS and eleven at telemedicine sites located at three Indian Reservation sites (Hualapai, Hopi and Gila River) and two Regional Behavioral Health Authority (RBHA) sites (Flagstaff and Tucson). See Attachment One and Two for a Listing of Participants and the Meeting Agenda.

### Welcome, Blessing, and Opening Comments:

Michael Allison (Navajo), Native American Liaison, at ADHS, provided the opening comments and functioned as the meeting Master of Ceremony. Filmer Lalio (Pueblo of Zuni), Coordinator, Native American Program, Banner Alzheimer's Institute, gave the traditional blessing. Will Humble, Director, ADHS provided additional welcoming remarks and provided an update on the status of integrated care contracting. The first draft of licensing regulations may be ready by April, 2012. Efforts are underway to initiate the RFP process for the RBHA contract for Maricopa County. The following question/comments were made and asked by Tribal representatives with replies from Will Humble:

Reuben Howard, Executive Director, Health Services Division, Pascua Yaqui Tribe commented that there should be reduction of requirements for Tribes due to smaller infrastructure and licensing requirements are duplicative. Will Humble replied he was open to discuss deemed status and other alternative options.

Loren Sekayumtewa, Director, Hopi Guidance Center commented that the approach must be unique to each Tribe. Tribes have recruitment & retention challenges and there are auto-enrollment issues, etc. Will Humble ask Mr. Sekayumtewa to put his comment/concerns into writing and he asked Michael Allison to follow up with Loren.

### Block Grants Presentation, Discussion and Recommendations:

Michael Sheldon, Manager, Office of Data Reporting & Analysis, ADHS-Division of Behavioral Health Services (DBHS) gave a power point presentation on the joint application process for the Substance Abuse Prevention and Treatment Block Grant (SAPT) and the Community Mental Health Services Block Grant (CMHS). The services cannot be Medicaid reimbursable services. The following question/comments were made with replies from ADHS staff.

Reuben Howard commented that the \$9-9 ½ million for the joint application should be based on need and traditional medicine should be allowed. Ann Froio, Assistant Director, ADHS-DBHS commented that the methodology for determining need must be developed and she did not see why traditional medicine could not be included.

## 1/18/2012 Behavioral Health Tribal Consultation Meeting Summary

Al Long, Senior Program and Project Specialist, Navajo Division of Health, Department of Behavioral Health asked why the Tribes were not consulted prior to ADHS submitting the joint application. Ann Froio apologized for this situation. She stated ADHS is committed to Tribal Consultation.

Dr. Bill Arnet, Director, Apache Behavioral Health Services, Inc. commented that TRBHAs could potentially get more funding based on needs. Ann Froio answered that this was a possibility based on documentation. Michael Sheldon commented that ADHS lacks American Indian total data.

Alida Montiel, Health System Analyst, Inter Tribal Council of Arizona, Inc. commented that there is a need for a Needs Methodology System because Tribes, Indian Health Service (IHS) and urban Indian information is lacking in the state data system. Giving the timeframe there might be a case to hire a consultant to work on the methodology. Ann Froio commented that this was a good suggestion. Lydia Hubbard-Pourier, TRBHA Contract Administrator, ADHS-DBHS commented that the challenge will be obtaining data from the 638 programs as they receive Medicaid payment through an all inclusive rate and do not have utilization rates. Michael Sheldon commented he could support the hiring of a consultant.

Loren Sekayumtewa commented that there is a need to invest dollars to determine the methodology. There are substance abuse and mental health dual diagnoses, domestic violence, elder abuse, etc. There is no higher level of care available on the reservations. There is a lack of cultural competency with RBHA providers. There is also a need for long term care. Needs are not being met. Ann Froio requested Mr. Sekayumtewa to put his comments into writing.

Reuben Howard commented that there is a need for Tribal input into the RBHA service delivery. He recommended a Working Group. Ann Froio and Michael Shelton agreed with this recommendation.

Al Long commented that he supports the Work Group recommendation. He also supported Loren Sekayumtewa's priority suggestion. Methodology need is beyond just ADHS. It includes IHS and SAMHSA. Michael Sheldon commented on the need to document undocumented needs.

Alida Montiel asked if a survey would be useful. Michael Sheldon commented he would support a survey approach.

Steve Green, CEO, Gila River Indian Community TRBHA commented that he supports the recommendation for a Tribal Work Group to work on methodology development.

Carol Chicharello, Tribal Relations Liaison, Arizona Department of Economic Security commented on the billing system and said that IHS is the payer of last resort for Indian people. Michael Sheldon commented that ADHS is payer of last resort per the grant guidelines. Ann Froio commented that this issue needs to be researched.

Coordination of Care Services, Discussion and Recommendations

Robert Sorce, Assistant Director, Health Care Development, ADHS-DBHS provided comments on the creation of a new ADHS-DBHS office called the Health Care Development. He provided a presentation on the background and status of the Maricopa County RBHA RFP. It is a new model for integrated health care for Seriously Mentally Ill patients/clients. ADHS is drafting revised behavioral health licensing rules to allow for integrated care. The current Magellan contract has been extended for one additional year to 10/01/2013. The new RFP should be issued during the summer of 2012. Per the Affordable Care Act health information exchanges must be established and everyone must have health coverage. The Supreme Court will soon hear the states' suit against the Affordable Care Act. The following questions and comments were made with ADHS staff answers:

Reuben Howard asked how electronic medical records would be handled and how the new Maricopa County RFP would effect on and off reservation American Indians. Robert Sorce commented that electronic medical records apply to all patient care, not just for behavioral health and that ADHS-DBHS is partnering with Magellan without any extra dollars for Magellan. Planning is not that far along to answer the on and off reservation question. He added that feedback is needed from everyone.

Steven Green commented that the Gila River Indian Community is already doing integration successfully.

Alida Montiel commented that ADHS needs to reach out to Maricopa County Tribes. Bob Sorce commented that the ADHS Raise Your Voice effort was to obtained community input.

Loren Sekayumtewa commented that there is a need to consider urban Indians in ADHS planning. American Indians are not included up front as is required. There is a difference between American Indian and non-Indian definition of mental health. There is a need for capacity building support for Tribes. There is a need for system compatibility. Due to state cuts to AHCCCS non-eligible AHCCCS American Indian patients are turning to IHS for care. Robert Sorce commented he was supportive of Mr. Sekayumtewa's comments. AHCCCS service cuts are also impacting non-Indian patients. He added that in 2014 per the Affordable Care Act, the Medicaid eligibility will be 133% of poverty.

Alida Montiel commented that the team delivery of service provides better care. There is a need for screening tools. Who will do outreach to the Tribes? Robert Sorce agreed with Ms Montiel's comments. Tools are still under development. ADHS will do Tribal outreach.

Al Long commented that treatment must include traditional medicine and other patient choice including faith based treatment. There needs to be outreach to IHS, other federal agencies and PL 93-638 Tribal contracted programs. Robert Sorce commented that some services are not reimbursable and that SAMHSA and CMS are aware and involved.

Closing Remarks

Ann Froio commented that this Tribal Consultation Meeting was long overdue to start our dialogue. She thanked everyone for their participation. Michael Allison commented that he would be preparing a report documenting the proceedings and outcome of the meeting and that he would be following up on the Work Group recommendation. Prior to finalization of the meeting report he would provide a draft to all participants noted as making comments. In response to a question from Alida Montiel, Ann Froio commented that ADHS-DBHS Behavioral Health Tribal Consultations would be held on at least an annual basis.

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**Arizona Department of Health Services Division of Behavioral Health Services**

**Summary of Input from Behavioral Health Stakeholder Agencies**

**June 2012**

**Background Information**

On May 10, 2012 the Arizona Department of Health Services/Division of Behavioral Health Services solicited input from stakeholders/organizations that have a vested interest in:

- a) Adults with a Serious Mental Illness (SMI),
- b) Adults with a general mental health (GMH) or substance abuse (SA) challenge, and/or
- c) Children with behavioral health disorders

The forum was held at the State Laboratory from 1:30 – 3:30 pm. The eighteen (18) participants from different organizations that attended the forum were divided in three groups, and each group was assigned to answer three of the nine (9) questions included in the questionnaire. Group 1 was assigned questions 1-3; Group 2 was assigned questions 4-6; and Group 3 was assigned questions 7-9.

**Executive Summary**

Several items throughout this forum highlighted varying themes. Organizations that have positive impact on the current behavioral health system were peer-run, family-run organizations as well as liaisons to stakeholders that help bridge the connection of services. Also of note, several members noted that the J K Principles has provided a good support system while maneuvering through the behavioral health system to date. Other themes focused around accountability, duplication of effort and service-innovation. Accountability was as described as the lack of oversight by the State and that Regional Behavioral Health Authorities (RBHAs) were not following their own protocols thereby overlooking a check and balance within the behavioral health system. As for duplication of effort, participants indicated that it is the result of the lack of accountability. One solution brought forth was the idea of looking to other states like Vermont for innovation; if there are states who are carrying out a better system of care in behavioral health, then certainly Arizona should study, learn and take-away some of those innovations that may be able to enhance our current behavioral health system.

The questions and answers provided by the representatives who attended the forum are provided below. The forum adjourned at 3:30 pm.

Below are the answers received. Answers are listed as received from each of the groups' notes with minor editing for clarification and readability; they reflect the voice of the participants.

**Forum Question and Answers**

- 1) Describe what is currently working well in the existing public behavioral health delivery system that you would like to preserve in the next Maricopa County RBHA contract.
- 2) Describe features of the current behavioral health system that are the most helpful for the programs/services in your agency.

- D1: Crisis Team by Terros is responsive but need:
  - More teams
  - DDD Liaison
- DDD Stop Down: could be improved with more beds
- Whole team CFT when CFT members are well-trained
- From others in the group:
  - Peer-Run organizations, they work.
  - We have a good choice of providers to go to; there are liaisons to various stakeholders.
  - JK Principles that have built a good support system-We would love to benefit from that system. We would like to be able to tap into processes that are working.
  - Family-run organizations are working.
  - Magellan having a forensic coordinator is a great; in the jail population, we have mental health people, who are released, then come back again.
  - A much more formal relationship with ADHS/PNO/Juvenile Corrections/RBHA.
  - Once they are in the jail, they can't get out for misdemeanor charges because they can't get their trial to go on. Evidence based practices and clinical model.
  - Liaison to stakeholder agencies is helpful for connection to services
- Barriers from others in the group:
  - CFT/ACT process that works.
  - Competing demands for CM staff that can respond immediately without competing interest.
  - Dealing with more forensic-peer coordinators, people who have struggled in the jail with mental illness and they can maneuver the justice system. We can't just depend on a system of volunteers.
  - La Frontera has created a navigator-peer system, going back to follow-up-fairly new.
  - Down in Pima, they have to deal with how to navigate how to get IDs, housing, transportation, etc.
  - Criminogenic factors: sense of breaking the law vs. getting my needs met.
  - Having direct supports in the homes for the families that are working.

- 3) Describe areas of the behavioral health system (challenges/barriers) that impact the programs/services of your agency.

- Prior authorization communication with RBHA is inconsistent
- Low capacity for specialty services and no capability to solve the problem: no autism, BH, sex offender issues
- RBHA has low capacity/ability to increase service capacity outside of 6 MH services
- System lack timeliness of services



- RBHA does not meet DDD client needs, JPO sex offenders needs or CPS intensive need youth (out of state kids)
- Networks are inefficient and duplicative layer of services
- Capitation and resulting layers creates poor responsiveness
- Limited services for non Title 19 kids and no willingness to solve problems
- Transition services to adulthood are not organized, prioritized
- Stepdown and level of care determinations are not being adhered to or follow RBHA's own protocols
- RBHA and providers do not understand criminogenic factors
- Funding allocation does not follow the kid
- Spend most money on prescription and case management and not on direct mental health services
- RBHA Admin costs are too high at each level of the system resulting in loss of services to kids/families
- Intensive services not provided due to prioritizing prescription/case management services
- Dosage and duration of services
- Contractors not held accountable my Maricopa compared to other RBHAs
- Others in group:
  - CFT becomes the gatekeeper for out of home care services, no capability to solve the problem (i.e. autism)
  - Capitation as a disincentive to a service provision
  - System lacks timeliness defined which is left to discussion
  - Lack of adherence to the 12 principles
  - Out of state kids
  - Network system layers of services
  - Limits timeliness
  - Financial issues
  - RBHA is not thorough and not adhering to 45 day assessment
  - Transition to adulthood not adhered
  - RBHA protocols not consistent with other protocols
  - Do not understand criminogenic processes/services
  - Most dollars not spent on direct mental health services (intensive services, dosages)
  - Contractors are not being held to standards of levels of care
  - Accountability

***Group 2 elected to answer all three questions summary-style, addressing all three questions at one time, according to the agency they were representing.***

- 4) How do your agency coordinate behavioral health and/or physical health care/services for members (i.e. access to behavioral health services, referrals, follow-up, Psychiatric visits, PCP visits, etc)?
- 5) What barriers do you encounter when coordinating care/services between your program/services and the behavioral health system?

6) What barriers do you encounter when coordinating care/services between your program/services and the behavioral and physical health system?

AJDC-Youth:

- Release you -> parole/supervised: Try to get a referral to ensure continuation of care
  - Payment issues
- Send with meds: Transition planning treatment teams have care plan coordinator
  - To get appointment -> need a payment system prior to appointment
  - AHCCCS eligibility – System works but timing is an issue
- Adults – Same problems getting services; challenges apply when a new provider comes on board
- Officers can make a suggestion for referral but need a parent/guardian to apply
- Judges can order but parent may still not follow through
- Detention = Non-criminal => AHCCCS eligible; can make a behavioral health referral while in detention
- “New kids” vs. “old kids” – Can get meds/diagnoses; but different and conflicting diagnoses and treatments

OSCHN:

- Job is coordinating the multiple systems with which the child is ostensibly connected
  - Multiple for payers
  - Confusing systems

Adult Corrections:

- Stigma – Access to care
- Navigators should be helpful
  - Is outpatient med length specified in contract
  - Lack of support/treatment for substance abuse
  - Privatization creates communication barriers

CPS:

- Youth aging out of foster care
  - SMI-Transition to adult MH system
  - Delays in waiting for qualified therapies
  - RBHAs not contracting with CPS therapists
- CPS maintains separate MH services – They pay child and family teams
  - Sometime UM @ RBHA does not authorize services
- Timeliness of services for high-need people
- Turnover of staff

## DDD/BHS:

- Why are we excluded from the integrated model?
- Support coordination in the division – RBHA liaison; BH specialists
- Review high profile cases monthly
  - Crisis mobile teams limited – Terros
  - Lack of RTCs; concern about level of disability
  - Providers not trained to serve DDD patients
  - Lack of professionals to diagnose or treat autism
  - Highest codes used meds and case management

## Pediatric Health Care:

- Coordinate with difficulty
  - Communication is poor
  - Lack of behavioral health inpatient beds
  - PCPs handcuffed in treatment

## Others in the group:

- CPS also has this concern on how this is going to cover development disability; how is the continuity going to be addressed.
  - Challenge-It talks about a revised model for adults but not to everybody else; also concerned about the exemptions, as you narrow people down (carved out SMI, GMH, SA, etc)-A lot of those people are one in the same person, so it may fit ¾ of you, what happens to the ¼ of you? That is the serious challenge.
  - There are so many layers now that they have siphoned off the \$\$-Carved out so much and when you have a RBHA that is using 60-70% of the \$\$; and ADHS is not helping them to get out of their own way to get at those case management dollars.
  - Concept of a medical home is a problem because it defines who these people are and the rest be damned. Instead of streamlining, there is a duplication process and admin costs are doubled. They see that this is a problem we need to serve the whole person and not just the body parts. We are not looking at this as more as competition vs. a more supportive model, so that you are catching people a little bit better. Principle: How do you actually make things work together?
- 7) What can help you better coordinate care for your members enrolled in your programs/services and in the behavioral health system?
- Streamline multiple agencies and multiple application processes.
  - Need for total case management/care coordination for multi-system involved youth/adults
  - Adherence to current care coordination policies vs. real world practice

- More comprehensive cross-training of the “nuts and bolts” of all sister agencies
- Care coordination at the primary care level (Vermont Model)
- Public and private partnership should be better developed
- Improve continuity and quality of agency’s care coordinators.

8) How can you improve the relationships between your agency, ADHS/DBHS, behavioral health providers, physical health care providers, and/or administrators from different agencies and programs to coordinate care? What new relationships would be helpful to you?

- More action, less talk
- Investment, particularly at all levels agency
- More involvement of family members
- Increase PH care coordinators and family meetings
- Patient-centered Medical Homes
- Front-line coordinators who deal with families-Peer-run/family-run organizations
- Integration of Behavioral Health and Physical Health

9) What would help improve your overall experience working with the public behavioral health system in Maricopa County?

- Chutes & Ladders approach – Multiple players with multiple roles – Need a primary care coordinator
- Simplify system (too many layers)
- Point of entry
- Behavioral Health providers and system needing to take ownership
  - Need for accountability
    - AHCCCS
    - DBHS
    - Provider ->RBHA and vice versa

Others in group:

- Timeliness is becoming the barrier, no way to hold anyone accountable; if you can’t measure it, you can’t count it.
- Is 90% too much to ask (assessment should be today)... the systems issue is who is going to be paying for it, AND what is being offered in the interim while the payment issue is resolved.
- Pediatric-Working with emergency rooms for ‘boarding’ because there is a lack of BH beds, is there a way to provide treatment while they are in the ER or hospital bed-Do we have data on the number of days? Example: Interim services with CRT, the kid is in ER misbehaved, and CPS had to come in and babysit the kid, but they don’t have behavioral health training.

- Trusting the agency to provide service is not being followed because of the funding issue- resources is limited in the first place because of the system limitation.
- There has got to be an easier way to move funds around but nobody seems to know that-You can't determine how many kids that are going to particularly.
- What is the oversight of the RBHA system; lack of proper oversight from the state.
- AHCCCS has the ability to say to the plan to cap/corrective action for accountability; with the RBHA, there is not.
- What is the alternative for bad behavior and accountability? There is not that same check and balance?
- What is the incentive to be timely when there is no competition; that is a system issue.
- We don't hold them in the contract, we have timeframes. I've got specialists who audit them, but I don't see any of that in the RBHA; systemic way of monitoring and dealing with the issue.

## Questions for Stakeholder Forum

May 10, 2012

The following questions are meant for “sister” agencies and partner organizations who serve individuals with general mental health (GMH) issues, substance abuse (SA) issues, Serious Mental Illness (SMI), and children receiving services through the public behavioral health delivery system.

- 1) Describe what is currently working well in the existing public behavioral health delivery system that you would like to preserve in the next Maricopa County RBHA contract.
- 2) Describe features of the current behavioral health system that are the most helpful for the programs/services in your agency.
- 3) Describe areas of the behavioral health system (challenges/barriers) that impact the programs/services of your agency.

*Care coordination is frequently described as the process by which members are linked to social supports and medical services, breaking down boundaries between systems of care, assisting members and families, and facilitating communication between all parties involved in the care of an individual.*

- 4) How do your agency coordinate behavioral health and/or physical health care/services for members (i.e. access to behavioral health services, referrals, follow-up, Psychiatric visits, PCP visits, etc)?
- 5) What barriers do you encounter when coordinating care/services between your program/services and the behavioral health system?
- 6) What barriers do you encounter when coordinating care/services between your program/services and the behavioral and physical health system?
- 7) What can help you better coordinate care for your members enrolled in your programs/services and in the behavioral health system?
- 8) How can you improve the relationships between your agency, ADHS/DBHS, behavioral health providers, physical health care providers, and/or administrators from different agencies and programs to coordinate care? What new relationships would be helpful to you?
- 9) What would help improve your overall experience working with the public behavioral health system in Maricopa County?

For more information and to provide additional feedback about integrating behavioral and physical health care in Maricopa County, visit <http://www.azdhs.gov/diro/integrated/index.htm> and use the “Contact Us” form located in the homepage.

## Summary of Feedback Received from Children and Youth (and their parent/guardian) Regarding Behavioral Health Services in Maricopa County

### Background Information

This report summarizes the input gathered during the forums conducted by the Arizona Department of Health/Division of Behavioral Health on April 12 and May 15, 2012. The overall purpose of the form was to gather input from children (or their parents) and adolescents receiving behavioral health services through the State and live in Maricopa County. The forum in April was co-hosted by Valle del Sol and the Jewish Family and Children Service (JFCS) and the forum in May was hosted by the Family Involvement Center (FIC).

### Participants

A total of 26 individuals participated in the two forums combined. Four of them participated in the April forum and twenty-two participated in the May forum. The specific breakdown is as follows:

- April 12: Four (4) participants attended the forum (three mothers and a 17-year old youth) as well as 18 administrators from various children's and behavioral health entities from the state of Arizona. The forum was held at Valle del Sol from 4:00 – 6:00 pm. Six questions (6) were posed to the four participants forming one group. The administrators in attendance were reminded that the forum was tailored specifically for members in the behavioral health system and while they couldn't participate, they were welcomed to stay and listen to the group discussion. All 18 administrators elected to stay and listen-in while the forum was being conducted.
- May 15: Twenty-two (22) participants attended the forum (14 adults ranging from 27 – 65 years old and 8 youth ranging from 14 to 22 years old). The forum was held at the Family Involvement Center (FIC) from 5:30 – 8:30 pm. Six questions (6) were posed to the participants who were divided into four (4) groups; two (2) adult groups, one youth group and one Spanish-speaking group who were provided an interpreter through FIC. The participants were divided into 4 groups, each group assigned to answer one particular question, and then subsequently answering the remaining questions.

Both forums were conducted according to the established protocol. Overall, the members were eager to be part of this process and to share with administrators and the State their concerns and experiences.

### Findings and Observations

#### *Current everyday experience receiving behavioral health services*

Participants shared both helpful and challenging aspects of their day-to-day experience receiving behavioral health services in Maricopa County. **Helpful aspects** included that the system is helpful, supportive, educative, and informative (i.e. available weight loss resources and information to help them become healthier). It also offers social engagement opportunities and youth programs (i.e. MYLIFE). **Challenging** aspects included that the system is difficult to deal with. The Participants described that the system is confusing, frustrating, and limiting with respect to coordination of services and getting the services needed. While one participant illustrated how challenging it was for her because she had to sell her car to have a place to live and now depends on the transportation provided by the system. She explained how despite calling her manager two to three days before her appointments "they" failed to provide her transportation

**Comment [O1]:** Unless the participants actually used this term, I suggest its replaced with "navigate"

**Comment [O2]:** This is confusing, not sure what it means.

services; another expressed that when it comes to transportation, the driver (service provider) is disrespectful and rude and ultimately creates an unwarranted amount of stress on her child; others also expressed frustration because they believed if they knew more about their diagnosis and/or treatment than their doctor, therapist, or social worker or because there wasn't enough programs, funding and professionals to meet his needs.

. Another example was from a youth who said he wished that he had received behavioral health services sooner (he didn't get services until he was 17 years old).

Participants also expressed frustration in regard to the lack of respect for and from behavioral health professionals. For example, one person described lack of respect and communication breakdown the fact that he had to wait one hour for his CFT (Child-Family Team) appointment because the doctor was running behind and no one had communicated this to him

#### ***Barriers to access behavioral health services***

The participants described the following as barriers to access to behavioral health services in Maricopa County:

Complexity of the system (i.e. difficult to understand the options available/services offered -- one person added that these "need condensing" and/or should be made available all in one place), difficulty getting into AHCCCS, too many referrals from agency to agency, and insufficient amount of services (i.e. not enough services available for children with multiple diagnosis so get put on waiting lists).

Lack of information: One person shared that she was told by X provider that they didn't have trauma therapists for her son yet seven years later she found that they did. persons felt that they had to fight with people to get the help they need.

#### ***Challenges or barriers while receiving behavioral health services***

Challenges or barriers encountered by the participants while receiving services in Maricopa County included poor case management, employees always changing, inconsistent care, insufficient services (i.e. children with multiple diagnosis get put on waiting lists), insufficient counseling services, lack of interpretation services during counseling, lack of parenting assistance or classes to help with children with behavioral diagnosis (one person specifically said that the RBHA had not followed through in getting him enrolled in the classes and his case manager was saying that he was enrolled), transportation, lack of continuity of care (particularly for transitioning youth), getting the right fit with providers, and length of consultations. Several persons expressed that their medication consultations were too short (15 – 20 minutes) and they felt it wasn't enough time for the doctors to determine the types of medication needed by their children. Several persons expressed feeling rushed during consultations. Another challenge shared was dealing with unprofessional staff. For example, one person said that a CPS worker lost her birth certificate and social security card. Another person mentioned "the way staff approach" him and the 9 other residents of a group home (i.e. always feeling rushed, always having to clean before eating or taking naps). One or more people felt disrespected and that they weren't heard. Poor transitioning planning was also a concern – the family of the youth in transition from children to adult services was not engaged. One or more participants also commented on lack of respect for culture and heritage during their treatment.

#### ***Programs or services helping the most in the person's recovery***



Please note that some of the youth participating indicated that they do not like the word “recovery” because to them mental illness is not something that can be recovered from but rather it’s something that needs to be managed. They said “Autism, Aspergers, etc. are not diagnoses that one recovers from.” With that in mind, they went ahead and answered the question.

Participants named several programs and/or services that they felt are helping them the most in their recovery (or management of their mental illness), these included: participating in the Youth Advisory Board, mentors, parents, religious groups, the Child and Family Teams (CFTs), community resources, roommates in group home, direct supports, community and provider guided training, and peer support. Parents agreed and one added that it was “amazing” having many teams that she can go to. Another parent named her Coach who taught her counseling, techniques and rules that she could show to her children. Specific programs and/or organizations also mentioned were My LIFE, Partners in Recovery, Tumbleweed, Youth Center, CFSS’s “Hanging with the Boys” program, JFCS, PAC line, and activities at FIC.

#### ***Programs or services helping the least in the person’s recovery***

Programs and/or services considered the least helpful for the person’s recovery (or management of mental illness) included: family counseling twice a month (i.e. the family members were the ones speaking not the youth), trauma coach/therapist, coaches who do not help or call, anger management groups for youth, in-office therapy, “traditional” parenting classes (i.e. it was suggested that the system removes court ordered- type classes because it is hard to follow their reading material), ineffective therapists, ineffective case managers, psychiatrist (i.e. one that doesn’t understand or respect the youth’s family culture/values; one that doesn’t identify the youth as a human being), residential placement, MST (Multi Systematic Therapy) because of “their” attitude (i.e. the staff’s attitude – “you have 90 days and you are out of there, you can’t push an ejection button; totally disrespectful”), not listening to the crisis or the upheaval (i.e. due to insufficient staffing), individual therapy for the child, adult case managers and the Magellan handbook.

Youth also talked about being asked ineffective qualifying questions by their case managers (i.e. Case managers using screening questions to see if the youth was qualified; the case manager asked as if expecting someone who is impaired). Specific programs or organizations mentioned were direct support from CFSS, Recovery Innovations, HOPE Network, Visions of Hope, and JFCS.

#### ***Suggestions to improve the member’s overall experience receiving behavioral health services***

Participants spoke of what may improve their experience receiving behavioral health services in Maricopa County. Suggestions included more individualized programs, integrating physical and mental health, help with goal setting and planning, having more staff to help youth, to be taken seriously with respect, empathy and understanding, professionalism (i.e. remove rude staff, return phone calls, follow through with plans i.e. at CFTs), activities and programs (including respite) for youth that won’t kick them out due to behavior, don’t stop services too soon (look more at ‘need’, not length of time), better skill-sets among all providers, more peer and parent supports, more trained mentors, be “honest and ‘up-front’ with recipients regarding what insurance will cover”, expand telemedicine access, more access to parenting/behavior classes, and classes for parents to deal with their children, more workshops on behavior building for children, parent counseling and medication for stress as needed, faster referrals and follow-ups for classes and for getting services (i.e. had to wait one year to get a coach), remove the ‘big black hole’ in placement to placement (i.e. Therapeutic Group Home), and more transportation assistance (i.e. when there is a mother of 4 or 5 and does not have an income and she doesn’t live where buses run.).

Participants also recommended improved communication and collaboration between all the agencies (government, RBHA, and providers), and communication between agencies and the families. Several participants asked that providers get better trained to explain services and options available and that the “Magellan handbook” gets improved (i.e. “it doesn’t help –need a better resource list”).

The youth also commented on their need for access to help on other areas of their lives. One idea suggested having a ‘center’ where to go to get help, i.e. “currently filling out my FAFSA application, would like someone to help me fill it out

**Comment [03]:** I suggest we restructure this paragraph, its too long and confusing. The beginning statement suggest that the problem seems to be the frequency of services rather than services per se and later we mention sites rather than programs.

who isn't my case manager, someone who can help me and not do it for me." Another comment was "one of my peers is trying to get a house, help us, show us what we need to do to get this house." Another suggestion was to create Unified Programs through a network which implements a youth network board to cater to the current youth issues and/or hardships foreseen within their near and/or far futures. Lastly, another group added "design strategies helping youth build a collective direction working as a functioning unit for the network."

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## Forum Questions

The following questions are for parents of children who are members or child/adolescent members representing themselves:

- 1) How would you describe your everyday experience receiving behavioral health services, either for you (if you're a child enrolled in services) or for your child enrolled in services through the Arizona public system (the State)?
- 2) What challenges or barriers have you encountered when trying to access behavioral health services?
- 3) What challenges or barriers have you encountered while receiving behavioral health services?
- 4) What programs or services would you say are helping you the most in your recovery?
- 5) What programs or services are the least helpful to your recovery?
- 6) What would help improve your overall experience receiving behavioral health services?

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